

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01501

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Louise H. Blizzard</b>				2. Date of Death Month <b>1</b> Day <b>14</b> Year <b>04</b>		3. Time of Death <b>1805</b>	
4a. Facility Name (If not institution, give street and number) <b>412 Robbins Terrace</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegheny</b>	
5. Social Security Number <b>220 16 2533</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>01/22/23</b>	
9. Birthplace (State or Foreign Country) <b>MD</b>		Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Allegheny</b>		10c. City, Town or Location <b>Cumberland</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>412 Robbins Terrace</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>		16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) <b>Richard Head</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>A. Loretta Lee</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Susan Blizzard</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1936 Durham Drive Cumb. Md. 21502</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WVU Human Gift Registry</b>		20c. Location - City or Town, State <b>1/14/04 Morgantown, W.VA</b>		20d. Date	
21. Signature of Funeral Service Licensee <b>Robert J. Bolvard</b>				22. Name and Address of Facility <b>Human Gift Registry WVU 4052 Health Sciences North Morgantown, WV 26506</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Endstage Lung Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>5 yrs</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Dr. Wagoner MD</b>				29c. License number <b>D22181</b>		29d. Date signed (Month, Day, Year) <b>January 14, 2004</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>925 Bishop Walsh Drive Cumberland, Md. 21502</b>							
31. Date filed (Month, Day, Year) <b>JAN 22 2004</b>				32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01502

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bernice Alice Crawford

2. Date of Death  
Month Day Year

Jan 04 2004

3. Time of Death

0450 M

4a. Facility Name (If not institution, give street and number)

Mallard Bay Nursing Home

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

161-16-8283

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth  
(Month, Day, Year)

March 14, 1912

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Hurlock

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6662 Cabin Creek Road (P.O. BOX 395)

10f. Zip Code

21643

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?☐ Yes ☒ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

House Keeping

16b. Kind of Business/Industry

Cold Water

17. Father's Name (First, Middle, Last)

Peter Johns

18. Mother's Name (First, Middle, Maiden Surname)

Carvilla Mae Johns

19a. Informant's Name/Relationship (Type, Print)

Eleanor Williams / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22913 Dover Bridge Road, Preston, Maryland 21655

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Washington Cemetery 01/09/2004

Date

20c. Location - City or Town, State

Hurlock, Maryland

21. Signature of Funeral Service Licensee

John A. Prince

22. Name and Address of Facility

Bennie Smith Funeral Home  
516 S. Main Street, Hurlock, Maryland 2164323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Pancreatic Cancer

Approximate  
Interval Between  
Onset and Death

3 mos

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an  
autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ NoHospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending  
investigation☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Michael J. Padellaro

29c. License number

D26388

29d. Date signed (Month, Day, Year)

Jan 06, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. Padellaro MD 302 Collins Hurlock MD 21643

31. Date filed (Month, Day, Year)

Jan 09 2004

32. Registrar's Signature

John A. Prince

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Idonac Charleron  
04-0220  
AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01503

1- For State Registrar

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>IDONAC CHARLERON</b>		2. Date of Death Month <b>January</b> Day <b>8</b> Year <b>2004</b>		3. Time of Death <b>7:21 P M</b>	
4a. Facility Name (If not institution, give street and number) <b>Route 318 and Route 331</b>		4b. City, Town, or Location of Death <b>Preston</b>		4c. County of Death <b>Caroline</b>	
5. Social Security Number <b>219-57-9713</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>24</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>June 18, 1979</b>		9. Birthplace (State or Foreign Country) <b>Haiti</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Federalsburg</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>136 Kerney Street</b>		10f. Zip Code <b>21632</b>		10g. Citizen of What Country? <b>Haiti</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Poultry Worker</b>		16b. Kind of Business/Industry <b>Poultry</b>	
17. Father's Name (First, Middle, Last) <b>Inoder Charleron</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Rosemere Charleron</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Inoder Charleron/Father</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>136 Kerney Street, Federalsburg, MD 21632</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>Federal Hill Cem.</b>		20c. Location - City or Town, State <b>1/17/2004 Federalsburg, MD</b>	
21. Signature of Funeral Service Licensee <b>Christine M. Coale</b>		22. Name and Address of Facility <b>Frampton Funeral Home, PA 216 N. Main St. Federalsburg, MD 21632</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>head injuries</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>At scene</b>			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>1-8-4</b>		28b. Time of Injury <b>19:14</b> M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Driver of motor vehicle involved in accident</b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Preston, MD</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Patricia Aronica-Pollak</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>January 9, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PATRICIA ARONICA-POLLAK MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 13 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2004 01504

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) WILLIAM DAVID CROPPER SR.				2. Date of Death Month Day Year 1 01 2004		3. Time of Death 0210 M	
4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death Wicomico	
5. Social Security Number 217-30-9709		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) June 5, 1936	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Hebron		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 7320 Levin Dashiell Rd.				10f. Zip Code 21830		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Army		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Manager		16b. Kind of Business/Industry Chevrolet Sales	
17. Father's Name (First, Middle, Last) Herman David Cropper				18. Mother's Name (First, Middle, Maiden Surname) Pauline Lynch			
19a. Informant's Name/Relationship (Type, Print) Joanne Cropper/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7320 Levin Dashiell Rd., Hebron, MD 21830			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) E. New Market Cemetery		Date 1/5/03		20c. Location - City or Town, State E. New Market, MD	
21. Signature of Funeral Service Licensee David H. Thompson CFSP				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary embolism b. Lung cancer c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Kurt Wenberg				29c. License number 046536		29d. Date signed (Month, Day, Year) 1/2/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kurt Wenberg, M.D. 201 PINE RIDGE RD SALISBURY MD 21801							
31. Date filed (Month, Day, Year) JAN 06 2004				32. Registrar's Signature Benjamin B Sparks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01505

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Gertrude Chaney

2. Date of Death

January 10, 2004

3. Time of Death

6:30 P M

4a. Facility Name (If not institution, give street and number)

Millennium Health Center

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

224-48-2915

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 15, 1912

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Mayo

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1220 Pine Avenue

10f. Zip Code

21106

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Adam G. Keener

18. Mother's Name (First, Middle, Maiden Surname)

Louisa Ulrich

19a. Informant's Name/Relationship (Type, Print)

James W. Chaney/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1222 Beach Rd., Mayo, Maryland 21106

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

National Mem'l. Park

Date

1-15-04

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cancer of the Head &amp; Neck with metastasis 1 month

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 50653

29d. Date signed (Month, Day, Year)

1-12-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5851 - Deale Churchton Road. Deale MD. 20751

31. Date filed (Month, Day, Year)

JAN 12 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Roland Colbert  
04-0106  
AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01506

1- For State Registrar

Physician /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0036  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Roland Colbert		2. Date of Death Month Day Year January 4, 2004		3. Time of Death 20:59 P <sup>M</sup>	
4a. Facility Name (If not institution, give street and number) 536 N. Pulaski Street		4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
5. Social Security Number 218-26-7668		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.	
8. Date of Birth (Month, Day, Year) June 25 1933		9. Birthplace (State or Foreign Country) D.C.			
10a. State Maryland		10b. County None		10c. City, Town or Location Baltimore	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 536 N. Pulaski St.		10f. Zip Code 21223	
10g. Citizen of What Country? USA		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th 2yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LPN-Nurse		16b. Kind of Business/Industry University Of Md. Hospital	
17. Father's Name (First, Middle, Last) Roland Colbert Sr.		18. Mother's Name (First, Middle, Maiden Sumame) Clara Holland			
19a. Informant's Name/Relationship (Type, Print) Terry T. Brown(Nephew)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2326 Eutaw Place Baltimore, Md. 21217			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Baltimore, Md.	
21. Signature of Funeral Service Licensee Larry B. Reese M60487		22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) At scene			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Margarita Korell M.D.		29c. License number O.C.M.E.	
29d. Date signed (Month, Day, Year) January 5, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) JAN 12 2004		32. Registrar's Signature Dean S. Smith			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01507

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter Stanton Cook, Jr.

2. Date of Death

January 5, 2004

3. Time of Death

1:30 p<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

5. Social Security Number

276-12-0049

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 30, 1919

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8100 Elmberry Court Apt. # 1302

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No WW II

If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Shoe Store

17. Father's Name (First, Middle, Last)

Walter S. Cook, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Kathryne H. Hardenburgh

19a. Informant's Name/Relationship (Type, Print)

Linda Ferguson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8100 Elmberry Court Apt. 1302 Pasadena, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

January 9, 2004

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco &amp; Sons, P.A. Severna Park Funeral Home

495 Gov. Ritchie Hwy. Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Oculo-pharyngeal muscular dystrophy

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D50725

29d. Date signed (Month, Day, Year)

1-5-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Riedinger 8601 Veterans Hwy Millersville, MD 21108

31. Date filed (Month, Day, Year)

JAN 08 2004

32. Registrar's Signature

John B. Smith

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01508

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

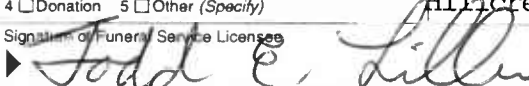
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Mary Francis Clark</b>				2. Date of Death Month Day Year <b>January 8 2004</b>		3. Time of Death <b>2:50 A<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>220-16-9056</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 30, 1926</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>24 Oak Court</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Edward Craig</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eugie Fitzhugh</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Susan Morris/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24 Oak Court Annapolis, MD 21401</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hillcrest Mem. Gardens</b>		Date <b>1/10/2004</b>		20c. Location - City or Town, State <b>Annapolis, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Congestive Heart Failure</b> Due to (or as a consequence of): b. <b>Hypertensive Crisis</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>3 days</b> <b>3 days</b>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Disease</b>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number <b>D 0056955</b>		29d. Date signed (Month, Day, Year) <b>Jan. 8, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bryan J. McVerry AAMC 2002 Medical Parkway Annapolis, Maryland 21401</b>							
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>				32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01509

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Anna Cross</b>				2. Date of Death Month <b>Jan</b> Day <b>1</b> Year <b>2004</b>				3. Time of Death <b>1:15 A<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>Moran Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Westernport</b>				4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>202-26-5720</b>		6. Sex <b>1</b> M <b>2</b> F <input checked="" type="checkbox"/> <b>X</b>		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 18 1906</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Md</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Westernport</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> <b>X</b> Yes <input type="checkbox"/> No				10e. Street and Number <b>233 Maryland Ave</b>				10f. Zip Code <b>21562</b>	
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status <b>1</b> <input checked="" type="checkbox"/> <b>X</b> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> <b>X</b> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> <b>X</b> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (1-4or 5+)</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maid</b>				16b. Kind of Business/Industry <b>Homecare</b>				17. Father's Name (First, Middle, Last) <b>John Cross</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Vidiki</b>				19a. Informant's Name/Relationship (Type, Print) <b>Julia Price</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>302 Maryland Ave, Westernport, Md 21562</b>	
	20a. Method of Disposition <b>1</b> <input checked="" type="checkbox"/> <b>X</b> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St Peters Cem</b>				20c. Location - City or Town, State <b>Jan 3, 2004 Westernport, Md</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Boal Funeral Home 111 Church St Westernport, Md 21562</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Acute myocardial Infarction</b> Due to (or as a consequence of): <b>b. Coronary Artery Disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	
	23b. Was decedent pregnant in the past 12 months? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>9</b> <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <b>1</b> <input type="checkbox"/> Live birth <b>2</b> <input type="checkbox"/> Fetal death <b>4</b> <input type="checkbox"/> Pregnant at time of death <b>5</b> <input type="checkbox"/> Other (specify) <b>9</b> <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Organic Brain Syndrome</b>				23e. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input checked="" type="checkbox"/> <b>X</b> Unknown				24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> <b>X</b> No	
	24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No				25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> <b>X</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input checked="" type="checkbox"/> <b>X</b> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)	
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> <b>X</b> Natural <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>5</b> <input type="checkbox"/> Pending investigation <b>6</b> <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> <b>X</b> No				28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <b>1</b> <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> <b>X</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier 				29c. License number <b>D21244</b>				29d. Date signed (Month, Day, Year) <b>1/2/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Jesus Tan, Frostburg Plaza, Frostburg, Md. 21532</b>				31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>				32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend item #23 per PHY8293/1/04 EW Certificate of Death


Reg. No.

2004 01510

Physician  
/Medical  
Examiner

Funeral  
Director

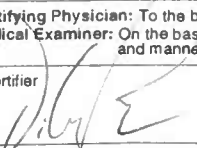

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Kathleen Elaine Chambers				2. Date of Death Month Day Year JANUARY 7, 2004		3. Time of Death 19:50 M	
4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
5. Social Security Number 212-92-7257		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 32 Yrs.		8. Date of Birth (Month, Day, Year) 05/19/1971	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 1942 Durham Drive				10f. Zip Code 21502		10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nursing Student		16b. Kind of Business/Industry Medical	
17. Father's Name (First, Middle, Last) Gerald Freeman Chambers				18. Mother's Name (First, Middle, Maiden Surname) Maria Therese Koenig			
19a. Informant's Name/Relationship (Type, Print) Gerald Chambers / father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1942 Durham Drive, Cumberland, Maryland 21502			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory		20c. Date 01/09/2004		20d. Location - City or Town, State Cumberland, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502			

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ANOXIC ENCEPHALOPATHY</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 WEEK	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D36766		29d. Date signed (Month, Day, Year) January 8, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POONAI, VIK, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502					
31. Date filed (Month, Day, Year) JAN 09 2004		32. Registrar's Signature 			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01511

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

JENNIFER JENKINS CHEEK

2. Date of Death

Month Day Year  
JANUARY 7, 2004

3. Time of Death

5:40 P M

4a. Facility Name (If not institution, give street and number)

406 SOUTH STREET

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

215-04-3789

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

20 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

SEPT. 3, 1983

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

406 SOUTH STREET

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STUDENT

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

PHILIP CHEEK

18. Mother's Name (First, Middle, Maiden Surname)

JESSIE DORAN

19a. Informant's Name/Relationship (Type, Print)

JESSIE CHEEK / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

406 SOUTH STREET, CUMBERLAND, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SUNSET MEMORIAL PARK

Date

01/12/2004

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee

*Sherry A. Upchurch*

22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE STREET, CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Abdominal incision infection

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

Seizure disorder

c. Due to (or as a consequence of):

Profound mental retardation

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

7 days

more than 10 years

more than 10 years

more than 10 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

9 ☐ Unknown

3 ☐ Ectopic pregnancy

5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral palsy - spastic quadriplegia  
Gastro-esophageal reflux disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Michael A. Levitar*

29c. License number

D38222

29d. Date signed (Month, Day, Year)

1/8/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael A. Levitar, MD 500 Greene St. Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JAN 0 8 2004

32. Registrar's Signature

*Sherry A. Upchurch*

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01512

1- For State Registrar

Physician / Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Guillermo Chacon-Zalles</b>				2. Date of Death Month <b>Jan.</b> Day <b>6</b> Year <b>2004</b>		3. Time of Death <b>7:15p</b> M	
4a. Facility Name (If not institution, give street and number) <b>3364 Hewitt Avenue #102</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>213-11-6824</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 10, 1915</b>	
				If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
9. Birthplace (State or Foreign Country) <b>Bolivia</b>							
Usual Residence of Decedent							
10a. State <b>Md</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3364 Hewitt Avenue #102</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Bolivian</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>		16b. Kind of Business/Industry <b>Accounting</b>	
17. Father's Name (First, Middle, Last) <b>Jose Chacon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elena Zalles</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Luis Catacora/Grandson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3109 Drumm Court Kensington, Md 20895</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven</b>		20c. Location - City or Town, State <b>Silver Spring, Md</b>	
20a. Date <b>1/09/04</b>							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md.</b>			

To Be Completed by Funeral Director

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. ampullary carcinoma</b> Due to (or as a consequence of): <b>b. dehydration</b> Due to (or as a consequence of): <b>c. jaundice</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D00058965</b>		29d. Date signed (Month, Day, Year) <b>1/07/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Saima U Khawaja, M.D. 11119 Rockville Pike Rockville, Md 20852</b>					
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature 			

To Be Completed by Physician/Medical Examiner

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01513

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) ROSE BERRY CHAYES				2. Date of Death Month Day Year JANUARY 1, 2004				3. Time of Death 2:00 A.M.					
4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON						4b. City, Town, or Location of Death ROCKVILLE				4c. County of Deeth MONTGOMERY			
5. Social Security Number 125-07-6778				6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) JULY 10, 1907		9. Birthplace (State or Foreign Country) PENNSYLVANIA			
Usual Residence of Decedent													
10a. State MARYLAND				10b. County MONTGOMERY				10c. City, Town or Location ROCKVILLE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 6121 MONTROSE ROAD						10f. Zip Code 20852				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME			
17. Father's Name (First, Middle, Last) JACOB STARK						18. Mother's Name (First, Middle, Maiden Surname) ESTHER KOFF							
19a. Informant's Name/Relationship (Type, Print) DR. F. NORMAN BERRY/SON						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6105 DURBIN RD., BETHESDA, MARYLAND 20817							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) NATIONAL CREMATORY				Date 1/2/04		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA			
21. Signature of Funeral Service Licensee Donald C. Stottmeyer						22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA												23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier Gregory A. Compton MD						29c. License number DZ4942				29d. Date signed (Month, Day, Year) JAN 01 2004			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GREGORY A. COMPTON, M.D., 6121 MONTROSE ROAD, ROCKVILLE, MARYLAND 20852													
31. Date filed (Month, Day, Year) JAN 07 2004				32. Registrar's Signature B. Sparks									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01514

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AUGUSTA THELMA COTTMAN

2. Date of Death

Jan. 4, 2004

3. Time of Death

7:02 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

17060 King James Way #611

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

174-26-3520

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 20, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

17060 King James Way #611

10f. Zip Code

20877

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Robert Butler

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Dixon

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Dobbins-Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13520 Hayworth Dr Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lincoln Mem Cem.

Date

1/12/2004

20c. Location - City or Town, State

Siutland, MD

21. Signature of Funeral Service Licensee

George R. Smith

22. Name and Address of Facility

Snowden Funeral Home, PA  
246 N. Washington St Rockville, MD 2085023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

UNCONTROLLED HYPERTENSION

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Melletus

Autonomic Neuropathy

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alan R. Vinitzky MD D22180

29c. License number

MD D22180

29d. Date signed (Month, Day, Year)

1/7/04

30. Name and address of person who completed cause of death (If not 23a) (Type, Name)

ALAN R VINITZKY MD SUITE 201 GAITHERSBURG MD 20878

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
important: if item 27 is marked other than "natural", or items 23e or 24e show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

AMEND ITEM #20b PER FH G828 2/10/04 Certificate of Death

Reg. No.

2004 01515

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles F. Crotty				2. Date of Death Month Day Year January 3, 2004				3. Time of Death 1330 M	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 723-10-6492		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) July 2, 1931		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 11722 Enid Drive				10f. Zip Code 20854		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean War		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Information Systems Analyst		16b. Kind of Business/Industry General Electric			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Leo A. Crotty				18. Mother's Name (First, Middle, Maiden Surname) Helen Failey					
	19a. Informant's Name/Relationship (Type, Print) Frances D. Crotty/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11722 Enid Drive, Potomac, Maryland 20854					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Gabriel's Cemetery		Date December 8, 2004 1/08/04		20c. Location - City or Town, State Potomac, Maryland			
	21. Signature of Funeral Service Licensee [Signature] M00803		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic carcinoma of unknown primary Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 4 months	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown								23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. upper gastrointestinal hemorrhage liver failure acute renal failure								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D43083		29d. Date signed (Month, Day, Year) JANUARY 04, 2004			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE A SOTOS, MD 9707 MEDICAL CENTER DRIVE, # 300 ROCKVILLE, MD 20850									
	31. Date filed (Month, Day, Year) JAN 05 2004		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01516

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

JOYCE MAXINE CONLEY

2. Date of Death

JAN 16, 2004

3. Time of Death

5:48P M

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral Director

5. Social Security Number

254-42-8797

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

DEC. 5, 1930

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

TENN.

Usual Residence of Decedent

10a. State

MARYLAND PRINCE GEORGE

10b. County

10c. City, Town or Location

ACCOKEEK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14910 SCHALL ROAD

10f. Zip Code

20607

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1950-52

ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FOOD SERVICE WORKER

16b. Kind of Business/Industry

P.G. BOARD OF ED.

17. Father's Name (First, Middle, Last)

KERRITT ROSEVELT REED

18. Mother's Name (First, Middle, Maiden Surname)

GLADYS ONEIDA KNOX

19a. Informant's Name/Relationship (Type, Print)

RICHARD F. CONLEY-SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1913 MICHAEL RD. WALDORF, MARYLAND 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TRINITY MEM. GARDENS

Date

1-21-04

20c. Location - City or Town, State

WALDORF, MARYLAND

21. Signature of Funeral Service Licensee

MO0479

22. Name and Address of Facility

RAYMOND FUNERAL SERVICE, P.A.

LA PLATA, MARYLAND 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No

3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown

3 ☐ Ectopic pregnancy

5 ☐ Other (Specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation, Deep vein thrombosis, coronary artery disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael A. Pimentel, MD

29c. License number

H-0042445

29d. Date signed (Month, Day, Year)

January 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael A Pimentel MD 601 Post Office Road Ste 1A Waldorf, MD 20602

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

[Signature]

State Registrar

Joyce Conley  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01517

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Ellen Derby

2. Date of Death

01 02 2004

3. Time of Death

12 15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

185-20-3944

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN 17 1928

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7290 KATHY STREET

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOHN CUNNANE

18. Mother's Name (First, Middle, Maiden Surname)

BELLA MACALINDEN

19a. Informant's Name/Relationship (Type, Print)

JOAN DERBY/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29323 WILL STREET, EASTON, MD 21601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CHESAPEAKE CREMATION

Date

CTR1-3-2004

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

JOHN R. MERCER

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA  
200 S. HARRISON ST EASTON, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Sepsis  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. pneumonia  
Due to (or as a consequence of):

days

c. chronic obstructive lung disease  
Due to (or as a consequence of):

years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes  
hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?M 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. C. Lee, MD

29c. License number

DS8922

29d. Date signed (Month, Day, Year)

1/2/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Lee MD 2001 Medical Parkway Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

John B. Ford

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01518

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VERNON R. DONOHO				2. Date of Death Month Day Year 01 05 2004		3. Time of Death 01:02 <sup>PM</sup>	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 220-12-0829		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	8. Date of Birth (Month, Day, Year) 03-26-1921		9. Birthplace (State or Foreign Country) MARDELA, MD.	
	Usual Residence of Decedent							
10a. State MD		10b. County WICOMICO		10c. City, Town or Location SALISBURY				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 5829 HAMMOND SCHOOL ROAD				10f. Zip Code 21804		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TOBACCO & CANDY INDUSTRY		16b. Kind of Business/Industry WHOLESALE		
17. Father's Name (First, Middle, Last) WILLIAM E. DONOHO				18. Mother's Name (First, Middle, Maiden Surname) MARY E. TRADER				
19a. Informant's Name/Relationship (Type, Print) GLORIA MARVEL DONOHO - SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5829 HAMMOND SCHOOL RD, SALISBURY, MARYLAND 21804				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SPRINGHILL MEM. GDNS.		Date 01-08-2004		20c. Location - City or Town, State SALISBURY, MD.		
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Pneumonia</i> Due to (or as a consequence of): b. <i>Acute CVA</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>1 wk</i> <i>10 d</i>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Paul R. Fleury MD</i>				29c. License number D24872		29d. Date signed (Month, Day, Year) 1/6/04		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL FLEURY MD 305 TENTH ST POCONOKE CITY, MD 21857								
31. Date filed (Month, Day, Year) JAN 06 2004				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01519

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Lyle Dick

2. Date of Death

Month Day Year  
Jan. 7, 2004

3. Time of Death

2:40 a M

4a. Facility Name (If not institution, give street and number)

13 Madary Road

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

722-12-6986

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Apr. 9, 1928

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13 Madary Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telephone Company Worker

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

George Albin Dick

18. Mother's Name (First, Middle, Maiden Surname)

Emily Elizabeth Bettis

19a. Informant's Name/Relationship (Type, Print)

Joan Dick/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 Madary Road, Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cemetery

Date

Jan. 10, 2004

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy, Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small Cell Lung Cancer

Due to (or as a consequence of):

b. Metastatic to Brain, Liver

Due to (or as a consequence of):

c. and bones

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

027938

29d. Date signed (Month, Day, Year)

January 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mayer G. G. 795 Agate Rd. Glen Burnie, MD 21061

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 12 2004

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

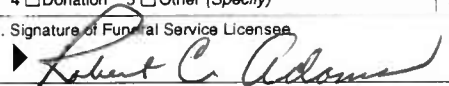


Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01520

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma Mae Davis				2. Date of Death Month Day Year January 5, 2004		3. Time of Death 8:25 A M		
	4a. Facility Name (If not institution, give street and number) 115 East Offutt Street				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany		
Funeral Director	5. Social Security Number 215-42-4625		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) 02/09/1935		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 115 East Offutt Street		10f. Zip Code 21502		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Homemaker		17. Father's Name (First, Middle, Last) Harry Luther Swandol		18. Mother's Name (First, Middle, Maiden Surname) Hannah Margaret Sciese	
19a. Informant's Name/Relationship (Type, Print) Michael L. Davis / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 E. Offutt Street, Cumberland, MD 21502					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Park Head UMC Cem.		20c. Date 01/08/2004		20d. Location - City or Town, State Big Pool, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD		a. Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia				23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D17565		29d. Date signed (Month, Day, Year) January 5, 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony J. Bollino, Jr., M.D., 922 National Highway, LaVale, MD 21502		31. Date filed (Month, Day, Year) JAN 06 2004		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01521

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alberto Diaz

2. Date of Death  
Month Day Year  
Jan. 2, 20043. Time of Death  
3:08a M

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director5. Social Security Number  
216-57-02826. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
68 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
6/14/19359. Birthplace (State or Foreign  
Country)  
Peru

Usual Residence of Decedent

10a. State  
Md10b. County  
Montgomery10c. City, Town or Location  
Silver Spring10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

3904 Bel Pre Road #7

10f. Zip Code

20906

10g. Citizen of What Country?

Peru

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☒ Yes 2 ☐ No Specify: Peru14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cleaner

16b. Kind of Business/Industry

Cleaning Company

17. Father's Name (First, Middle, Last)

Manuel Diaz

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Maria Pinedo

19a. Informant's Name/Relationship (Type, Print)

Olga Diaz/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3904 Bel Pre Road #7 Silver Spring, Md 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven

Date

1/05/04

20c. Location - City or Town, State

Silver Spring, Md

21. Signature of Funeral Service Licensee

Philip D. Rinaldi

22. Name and Address of Facility

PHILIP D. RINALDI FUNERAL SERVICE, P.A.  
9241 Columbia Blvd. Silver Spring, Md 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Septicemia

Due to (or as a consequence of):

Necrotizing Pancreatitis

Approximate  
Interval Between  
Onset and Death  
MO.

months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

Acute Respiratory Failure

days

c. Due to (or as a consequence of):

Multilple Organ Failure

days

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated

29b. Signature and title of certifier

Chukwuem Nwosu, MD

29c. License number

045391

29d. Date signed (Month, Day, Year)

Jan 02, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHUKWUEM NWOSU, MD 18101 Prince Philip Dr. Olney, MD

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

Benita S Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
5052.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01522

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eugene G. Donati

2. Date of Death

January 5, 2004

3. Time of Death

12:40 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

186-22-1675

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)  
March 10, 1930

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3636 Queen Mary Drive

10f. Zip Code

20832

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Orchestra Leader

16b. Kind of Business/Industry

Music

17. Father's Name (First, Middle, Last)

Guido Donati

18. Mother's Name (First, Middle, Maiden Surname)

Pia Boggi

19a. Informant's Name/Relationship (Type, Print)

Shirley H. Donati/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3636 Queen Mary Drive, Olney, MD 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven

Cemetery

Date

January 10

2004

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.

500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Respiratory Failure

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0058542

29d. Date signed (Month, Day, Year)

JAN 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Libus Heinz-Momckovic M.D. 11501 Georgia Avenue, #515, Wheaton, MD 20902

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01523

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marianthe S. Dracopoulos</b>				2. Date of Death Month Day Year <b>January 1, 2004</b>		3. Time of Death <b>11:25 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>4515 Willard Ave., Apt. 904 S.</b>				4b. City, Town, or Location of Death <b>Chevy Chase</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>215-18-8401</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 28, 1912</b>	9. Birthplace (State or Foreign Country) <b>St. Paul, MN</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Chevy Chase</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>4515 Willard Ave., Apt. 904 S</b>			10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Interior Decorator</b>		16b. Kind of Business/Industry <b>Upholstery Company</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Constantine Strenglis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eugenia Coulouris</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Theodora D. Argue/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9370 Mercerwood Dr., Mercer Island, WA98040</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		20c. Location - City or Town, State <b>Rockville, Maryland</b>		Date <b>1/5/2004</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc.</b>		22. Name and Address of Facility <b>5130 Wisconsin Ave., NW, Washington, DC 20016</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>2 Years</b>	
	a. <b>Left Ventricular Failure</b> Due to (or as a consequence of):						Years	
	b. <b>Aortic Stenosis</b> Due to (or as a consequence of):						Years	
	c. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier 	
	29c. License number <b>D39456</b>						29d. Date signed (Month, Day, Year) <b>January 5, 2004</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lila T. McConnell, M.D. 5530 Wisconsin Ave., #1400, Chevy Chase, MD 20815</b>							
	31. Date filed (Month, Day, Year) <b>JAN 08 2004</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01524

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Marie Drumm

2. Date of Death  
Month Day Year  
January 1, 20043. Time of Death  
12:41 a.m.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

198-01-3651

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 5, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5225 Pooks Hill Road, 328 South

10f. Zip Code

20814

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Electronic Company

17. Father's Name (First, Middle, Last)

Michael Patrick Reidy

18. Mother's Name (First, Middle, Maiden Surname)

Mary Genevieve Grattan

19a. Informant's Name/Relationship (Type, Print)

Cynthia Finelli/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7000 West Greenvalle Pkwy., Chevy Chase, MD 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery

Date

January 20 2004

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

James S. Dealey

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.  
500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 yrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard H. Power MD

29c. License number

D09577

29d. Date signed (Month, Day, Year)

1/1/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard H. Power MD

10400 CONNECTICUT AVE # 606  
KENSINGTON, MD 20895

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

James S. Dealey

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar


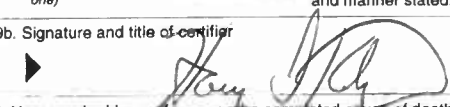
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01525

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Doris S. Dutch</b>				2. Date of Death Month <b>January</b> Day <b>3</b> Year <b>2004</b>				3. Time of Death <b>5:05 PM</b>					
4a. Facility Name (If not institution, give street and number) <b>9716 Lemocks Drive</b>				4b. City, Town, or Location of Death <b>Upper Marlboro</b>				4c. County of Death <b>Prince Georges</b>					
5. Social Security Number <b>577-58-8506</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>Nov. 4, 1944</b>		9. Birthplace (State or Foreign Country) <b>Wash. D.C.</b>	
Usual Residence of Decedent													
10a. State <b>MD.</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Upper Marlboro</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number <b>9716 Lemocks Drive</b>				10f. Zip Code <b>20772</b>				10g. Citizen of What Country? <b>United States</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Program Specialist</b>				16b. Kind of Business/Industry <b>Metro</b>					
17. Father's Name (First, Middle, Last) <b>William Louis Dutch</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Gloria Winifred Edge</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Wendell Anthony Person / Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5002 Lee Jay Drive, Capitol Heights, MD. 20743</b>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		Date <b>1/9/04</b>		20c. Location - City or Town, State <b>Landover, MD.</b>					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>McGuire Funeral Service</b> <b>7400 Georgia Ave., N.W. Wash. D.C. 20012</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Breast Cancer</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at this time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier 						29c. License number <b>D20352</b>		29d. Date signed (Month, Day, Year) <b>January 8, 2004</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Harvey I. Katzen, M.D. 7525 Greenway Center Dr., Greenbelt, MD. 20770</b>													
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>				32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01526

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph F. Elmo

2. Date of Death  
Month Day Year  
January 4, 20043. Time of Death  
2:30P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-09-1289

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94 Yrs.

8. Date of Birth (Month, Day, Year)

May 19, 1909

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13204 Glenhill Rd

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Superintendent

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Angelo Francis Elmo

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Joan Dramas

19a. Informant's Name/Relationship (Type, Print)

Katherine E. Fletcher/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9303 St. Andrews Pl, College Park, MD 20740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Crematory

Date

Jan 10, 2004

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
4 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urinary Tract Infection  
Insulin Dependent Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Wilkinson J. Nivala

29c. License number

D45285

29d. Date signed (Month, Day, Year)

January 4, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WJ Nivala, 344 University Blvd #113, Silver Spring, Md 20901

31. Date filed (Month, Day, Year)

JAN 08 2004

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01527

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Carol Ann Ellis

2. Date of Death

January 2, 2004

3. Time of Death

7:38 A M

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

216-40-8743

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 12, 1942

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10005 Renfrew Road

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Certified Dental Assistant

16b. Kind of Business/Industry

Dental

17. Father's Name (First, Middle, Last)

Paul Churan

18. Mother's Name (First, Middle, Maiden Surname)

Verna Muha

19a. Informant's Name/Relationship (Type, Print)

Andrew J. Ellis Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10005 Renfrew Road Silver Spring, Maryland 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Jan. 6, 2004 Silver Spring, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Irreversible Bowel Obstruction

Due to (or as a consequence of):

18 months

Sequentially list condition, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pseudomyxoma Peritonei

Due to (or as a consequence of):

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D02338

29d. Date signed (Month, Day, Year)

January 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard P. Delaney, M.D. 3929 Ferrara Drive Wheaton, Maryland 20906

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2004 01528

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Bessie ELFIN

2. Date of Death

Month Day Year  
January 8, 2004

3. Time of Death

1:20 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

133-09-2545

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 30, 1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6105 Montrose Road #2205 South

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Margolis

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Barr

19a. Informant's Name/Relationship (Type, Print)

Mel Elfin, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4515 - 30th St., NW, Washington, DC 20008

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

United Hebrew Cemetery 01/11/04

Date

20c. Location - City or Town, State

Staten Island, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Torchinsky Hebrew Funeral Home, Inc.

254 Carroll St., NW, Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bowel obstruction

Due to (or as a consequence of):

b. incarcerated hernia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic cardiovascular disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gary B. Wilks M.D.

29c. License number

D55258

29d. Date signed (Month, Day, Year)

January 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary B. Wilks, MD 6121 Montrose Road Rockville Maryland 20852

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

Barbara G. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

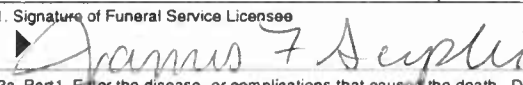
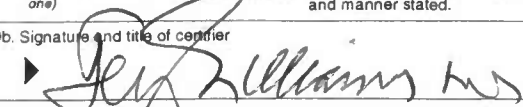
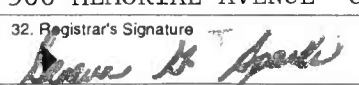
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01529

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clarence A. Emrick Sr.</b>			2. Date of Death Month Day Year <b>JANUARY 17 2004</b>		3. Time of Death <b>2040 P<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>213-22-3945</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar 26, 1926</b>	9. Birthplace (State or Foreign Country) <b>PA</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Allegany</b>	10c. City, Town or Location <b>Cumberland</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>710 Maryland Avenue</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Brakeman</b>		16b. Kind of Business/Industry <b>CSX Railroad</b>		
	17. Father's Name (First, Middle, Last) <b>Alfred E. Emrick</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Maude M. (Smith) Emrick</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Brian Emrick son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13115 Acre Lane Cumberland MD 21502</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hillcrest Memorial Park</b>		Date <b>1/21/2004</b>		20c. Location - City or Town, State <b>Cumberland MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Scarpelli Funeral Home, PA 108 Virginia Avenue Cumberland, MD 21502</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>RESPIRATORY ARREST</b> Due to (or as a consequence of): b. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>&lt; 2 WEEKS</b> <b>&gt; 5 YEARS</b>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D16041</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 19, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TERRY WILLIAMS, M.D. 500 MEMORIAL AVENUE CUMBERLAND, MD 21502</b>							
31. Date filed (Month, Day, Year) <b>JAN 22 2004</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State  
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01530

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CAROL A. FERRIERO

2. Date of Death  
Month Day Year

January 7 2004

3. Time of Death

0855 AM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital At Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

142-34-4256

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth  
(Month, Day, Year)

04/22/42

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Preston

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

22084 Haverkamp Road

10f. Zip Code

21655

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Associate

16b. Kind of Business/Industry

Walmart

17. Father's Name (First, Middle, Last)

Samuel Frantum

18. Mother's Name (First, Middle, Maiden Surname)

Jean Patricia Sarentino

19a. Informant's Name/Relationship (Type, Print)

Jean Ferriero/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23891 Carrlyn Dr., Ridgely, MD 21660

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bloomery Cemetery

Date

1/10/04

20c. Location - City or Town, State

Federalsburg, MD

21. Signature of Funeral Service Licensee

Christine M. Coale

22. Name and Address of Facility

Frampton Funeral Home, PA  
216 N. Main St., Federalsburg, MD 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Breast cancer - metastatic

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gram positive sepsis

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an  
autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Mary DeShields

29c. License number

D47232

29d. Date signed (Month, Day, Year)

1/07/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary DeShields, M.D., 509 Idlewild Ave. Easton, MD 21601

31. Date filed (Month, Day, Year)

JAN - 8 2004

32. Registrar's Signature

[Signature]

State  
RegistrarCarol Ann Ferriero  
Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0036To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01531

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT C. FERRAND

2. Date of Death

Month  
JAN.Day  
01Year  
2004

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

Salisbury Rehab and Nursing Center

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

116-07-0694

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
02-07-1913

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1401 GLEN AVENUE

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

CLARENCE FERRAND

18. Mother's Name (First, Middle, Maiden Surname)

ELSIE KIEFER

19a. Informant's Name/Relationship (Type, Print)

HELEN FERRAND - SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 GLEN AVENUE, SALISBURY, MARYLAND 21804

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CREMATORY OF DELMARVA

Date

01-03-04

20c. Location - City or Town, State

DELMAR, DELAWARE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BOUNDS FUNERAL HOME, INC.

705 EAST MAIN STREET, SALISBURY, MARYLAND 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. cerebrovascular accident  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

10 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension  
atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending  
investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30853

29d. Date signed (Month, Day, Year)

1/2/04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles B. Silva Jr.

1346 S. Division St. Suite, Salisbury, Md. 21804

31. Date filed (Month, Day, Year)

JAN 05 2004

32. Registrar's Signature

Benjamin S. Sparks

State  
RegistrarHERBERT C. FERRAND  
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01532

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NIKKI RAE FLEMETAKIS

2. Date of Death  
Month Day Year

January 6 2004

3. Time of Death  
M

3:00 A

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

562-90-7843

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

49

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

AUG 31 1954

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9360 Frances Street

10f. Zip Code

20603

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Nicholas Flemetakis

18. Mother's Name (First, Middle, Maiden Surname)

Ida O'Brien Flemetakis

19a. Informant's Name/Relationship (Type, Print)

April L. Oswald (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5408 Harvest Fish Place Waldorf, MD 20603

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory 1-7-04

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

M 00173

22. Name and Address of Facility

Eberwein Funeral Services

4433 White Pls. La. White Pls., MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Uroexis  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown23c. If yes, outcome of pregnancy  
☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown☐ Ectopic pregnancy  
☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an  
autopsy  
performed?  
☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
☐ Yes ☒ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Richard Palmer MD

29c. License number

D0055120

29d. Date signed (Month, Day, Year)

Jan 6 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Palmer MD 1328 Southern Avenue SE Suite 310 Washington DC 20032

31. Date filed (Month, Day, Year)

JAN 08 2004

32. Registrar's Signature

Kenna B. Spence

State  
Registrar

expired 1-6-04 3AM

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND320abcpccm/Crel/12/04,BW,MC Certificate of Death

Reg. No. 2004 01533

Physician /Medical Examiner  
Funeral Director  
Baltimore, Maryland 21215-0036  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <b>Keith Robert Fetridge</b>		2. Date of Death Month <b>JAN.</b> Day <b>2,</b> Year <b>2004</b>		3. Time of Death <b>0851 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>12903 THREE SISTERS ROAD</b>		4b. City, Town, or Location of Death <b>POTOMAC</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>028-46-0401</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>49</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Nov. 1, 1954</b>		9. Birthplace (State or Foreign Country) <b>New York</b>			
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>12908 Three Sisters Road</b>		10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Certified Public Accountant</b>		16b. Kind of Business/Industry <b>Accounting</b>	
17. Father's Name (First, Middle, Last) <b>Robert H. Fetridge</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Rute</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Ellen K. Fetridge/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12908 Three Sisters Road, Potomac, Maryland 20854</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation - <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery All Souls Cemetery, Rockville, Inc.</b>		20c. Location - City or Town, State <b>1/7/04 Germantown, Maryland</b>	
21. Signature of Funeral Service Licensee <b>W. Perry</b> M00803		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE CARBON MONOXIDE INTOXICATION</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>FUND 1-2-04</b>		28b. Time of Injury <b>2 350 AM</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>INHALED EXHAUST FUMES FROM CAR</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>12908THREE SISTERS RD MONTGOMERY, MD</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>W. Perry</b>		29c. License number <b>O.C.M.E</b>	
29d. Date signed (Month, Day, Year) <b>JAN. 3, 2004</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARGARET D. KOREN 111 Penn Street BALTIMORE, MARYLAND 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 05 2004</b>		32. Registrar's Signature <b>B Sparks</b>			

Reg. No. 2004 01534

**1- For  
State  
Registrar**

Reg. No.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last)  
Roland Fridell

2. Date of Death  
Month Day Year  
January 3, 2004

3. Time of Death  
10:45 AM

4a. Facility Name (If not institution, give street and number)  
4601 North Park Ave., 915

4b. City, Town, or Location of Death  
Chevy Chase

4c. County of Death  
Montgomery

5. Social Security Number  
577-16-1692

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
84 Yrs.

8. Date of Birth (Month, Day, Year)  
Nov. 17, 1919

9. Birthplace (State or Foreign Country)  
Washington, DC

10a. State  
Maryland

10b. County  
Montgomery

10c. City, Town or Location  
Chevy Chase

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number  
4601 North Park Ave., 915

10f. Zip Code  
20815

10g. Citizen of What Country?  
U.S.A.

11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Mechanical Engineer

16b. Kind of Business/Industry  
General Electric Company

17. Father's Name (First, Middle, Last)  
Willis Fridell

18. Mother's Name (First, Middle, Maiden Surname)  
Lillie Lee Holmes

19a. Informant's Name/Relationship (Type, Print)  
Monique Fridell / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
4601 North Park Ave., Apt. 1514, Chevy Chase, MD 20815

20a. Method of Disposition  
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Mt. Comfort Crematory

20c. Location - City or Town, State  
Alexandria, Virginia

20d. Date  
1-12-2004

21. Signature of Funeral Service Licensee  
M. C. Loder

22. Name and Address of Facility  
Joseph Gawler's Sons, Inc.  
MO1296 5130 Wisconsin Ave., NW, Washington DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
Pulmonary Fibrosis  
Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  
Due to (or as a consequence of):  
Approximate Interval Between Onset and Death  
18 Months

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
Chronic Hepatitis

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
Peter Hamm

29c. License number  
D32033

29d. Date signed (Month, Day, Year)  
January 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
Peter Hamm, M.D. 5530 Wisconsin Ave., #930 Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)  
JAN 08 2004

32. Registrar's Signature  
Benjamin S. Sparks

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01535

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRIEDRICH W. FLAD

2. Date of Death

Jan 4, 2004

3. Time of Death

12:38 Pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

214-52-7216

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 1, 1928

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7020 Wick Lane

10f. Zip Code

20855

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: German

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Physicist

16b. Kind of Business/Industry

Dent Of Defense

17. Father's Name (First, Middle, Last)

Oskar Flad

18. Mother's Name (First, Middle, Maiden Surname)

Anna Seyfang

19a. Informant's Name/Relationship (Type, Print)

Gilma Flad (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7020 Wick Lane, Derwood, Md #20855

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

1/6/04

20c. Location - City or Town, State

Alexandria, Va

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Snowden Funeral Home P.A. 20350  
246 N. Washington St., Rockville, Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
2 Months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)3 ☐ Ectopic pregnancy

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-35635

29d. Date signed (Month, Day, Year)

Jan 4, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Joseph Kaplan M.D. 18111 Prince Phillip Dr, Olney, Md #20832

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permi. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01536

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Louise S. Geib</b>		2. Date of Death Month <b>Jan.</b> Day <b>3</b> Year <b>2004</b>		3. Time of Death <b>7:45 am</b>	
4a. Facility Name (If not institution, give street and number) <b>GENESIS ELDERCARE-THE PINES</b>		4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>	
5. Social Security Number <b>216-18-2682</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>89</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>APR 22 1914</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>TALBOT</b>	10c. City, Town or Location <b>EASTON</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>501 DUTCHMANS LANE</b>		10f. Zip Code <b>21601</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>			
17. Father's Name (First, Middle, Last) <b>JOHN JESSE MULLIGAN SKINNER</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>ETHEL BENSON</b>		
19a. Informant's Name/Relationship (Type, Print) <b>ROBERT M. CATTANEO</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7768 WOODLAND CIRCLE, EASTON, MD 21601</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN MEMORIAL PARK</b>		20c. Location - City or Town, State <b>01-06-2004 EASTON, MARYLAND</b>	
21. Signature of Funeral Service Licensee <b>JOHN R. MERCER</b>		22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) <b>Cerebrovascular accident</b>					
Due to (or as a consequence of): <b>Atherosclerosis, generalized</b>					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Approximate Interval Between Onset and Death <b>8 months</b>					
Approximate Interval Between Onset and Death <b>years</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Gastrointestinal bleeding</b> <b>Anemia</b> <b>Hypothyroidism</b>					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Michael D. Crowley MD</b>		29c. License number <b>0725933</b>		29d. Date signed (Month, Day, Year) <b>1-3-04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL D. CROWLEY M.D. 508 IDLEWILD AVE., EASTON, MD 21601</b>					
31. Date filed (Month, Day, Year) <b>JAN 05 2004</b>		32. Registrar's Signature <b>Barbara S. Spaul</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01537

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Erma Mae Gatterman

2. Date of Death

Month Day Year  
JANUARY 05, 2004

3. Time of Death

12:30P M

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

211-38-5158

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Feb 9, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Grantsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

183 Ravine Street

10f. Zip Code

21536

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

Joseph Knopsnyder

18. Mother's Name (First, Middle, Maiden Surname)

Ella Dwire

19a. Informant's Name/Relationship (Type, Print)

Doris M. Beal/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

183 Ravine St., PO Box 365, Grantsville, MD 21536

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Addison Cemetery

Date

Jan 8, 2004

20c. Location - City or Town, State

Addison, PA

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Newman Funeral Homes, P.A., PO Box 275  
179 Miller St., Grantsville, MD 2153623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. RIGHT COLECTOMY FOR ADENOCARCINOMA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
17 DAYS

26 DAYS

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BACTERIAL LINE SEPSIS

DEMENTIA

URINARY TRACT INFECTION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

053158

29d. Date signed (Month, Day, Year)

JANUARY 5 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MICHAEL STASKO 924 SETON DRIVE CUMBERLAND, MARYLAND 21502

31. Date filed (Month, Day, Year)

JAN 08 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01538

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Diana Lee Grubb		2. Date of Death Month: January Day: 3, Year: 2004		3. Time of Death 0740 A M
	4a. Facility Name (If not institution, give street and number) 6000 Block Garrett Highway		4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett
Funeral Director	5. Social Security Number 232-96-4212	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	8. Date of Birth (Month, Day, Year) Jan. 28, 1957	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State: MD 10b. County: Garrett 10c. City, Town or Location: Oakland 10d. Inside City Limits: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number: 7876 George Washington Highway 10f. Zip Code: 21550 10g. Citizen of What Country?: USA		
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 11th College (1-4 or 5+): Associate		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Associate		16b. Kind of Business/Industry Wal-Mart		
	17. Father's Name (First, Middle, Last) Jesse ----- Doss		18. Mother's Name (First, Middle, Maiden Surname) Ellen ----- Bittinger		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) James H. Grubb/husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7876 George Washington Hwy., Oakland, Md. 21550		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fairview Cemetery		20c. Location - City or Town, State Oakland, Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries		Approximate Interval Between Onset and Death		
To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Unknown		
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month: Day: Year:		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) At Scene		
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 1-3-04		28b. Time of Injury 7:30 AM
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred DRIVEN OFF OF HIGHWAY		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway		28f. Location (Street and Number or Rural Route Number, City or Town, State) 6000 BLOCK GARRETT HIGHWAY GARRETT COUNTY		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 4, 2004
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGARET A. KORON 111 Penn Street, Baltimore, Maryland 21201				
State Registrar	31. Date filed (Month, Day, Year) JAN 05 2004		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01539

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Anne Mae Gue</b>		2. Date of Death Month <b>January</b> Day <b>6</b> Year <b>2004</b>		3. Time of Death <b>1:16 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>215-03-0399</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>December 20, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Mt. Airy</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>6120 Woodville Road</b>		10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>	
16b. Kind of Business/Industry <b>Clothing Factory</b>		17. Father's Name (First, Middle, Last) <b>James Donato Lettieri</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ada Wetzel</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Thomas Gue/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3800 Boteler Road/ Mt. Airy, Maryland 21771</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Prospect Cemetery</b>		20c. Location - City or Town, State <b>January 9, 2004 Mt. Airy, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 8 East Ridgeville Blvd./Mt. Airy, Maryland 21771</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Hypertension</b> a. Due to (or as a consequence of): <b>High cholesterol</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D47705</b>		29d. Date signed (Month, Day, Year) <b>1/6/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Nguyen, MD, 1564 Opossumtown Pike, Frederick, MD 21702</b>					
31. Date filed (Month, Day, Year) <b>JAN - 8 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01540

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES BURTON GLOVER

2. Date of Death  
Month Day Year  
January 4, 20043. Time of Death  
2:20 PM

4a. Facility Name (If not institution, give street and number)

Buckingham's Choice

4b. City, Town, or Location of Death

Adamstown

4c. County of Death

Frederick

Funeral  
Director5. Social Security Number  
442-16-27546. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
80 Yrs.8. Date of Birth  
(Month, Day, Year)  
Apr. 30, 19239. Birthplace (State or Foreign  
Country)  
Oklahoma

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Frederick10c. City, Town or Location  
Adamstown10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

3200 Baker Circle

10f. Zip Code

21710

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

FBI

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Julius Carmen Glover

18. Mother's Name (First, Middle, Maiden Surname)

Arliss Burton

19a. Informant's Name/Relationship (Type, Print)

Richard Glover (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9909 Ritchie Drive, Ijamsville, Maryland 21754

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Smithsburg Crematory

Date

1/6/04

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.  
1201 NORTH MARKET ST., FREDERICK, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. METASTATIC CARCINOMA

6 weeks

Due to (or as a consequence of):

b. CARCINOMA OF OROPHARYNX

12 months

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician  
2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D-31912

1/07/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julius Glover, MD 1564 Opossumtown Pike, Frederick MD 21702

31. Date filed (Month, Day, Year)

JAN - 8 2004

32. Registrar's Signature

Benita B Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01541

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FLORENCE GOODMAN</b>				2. Date of Death Month Day Year <b>JANUARY 2, 2004</b>		3. Time of Death <b>6:00P M</b>		
	4a. Facility Name (If not institution, give street and number) <b>MANOR CARE</b>				4b. City, Town, or Location of Death <b>POTOMAC</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>578-01-5886</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC 4, 1912</b>		
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>POTOMAC</b>		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>10714 POTOMAC TENNIS LANE</b>		10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ADMINISTRATIVE ASSISTANT</b>		16b. Kind of Business/Industry <b>HEALTH AND EDUCATION WELFARE</b>				
	17. Father's Name (First, Middle, Last) <b>LOUIS ZIMMERMAN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>FANNIE SNYDER</b>		19a. Informant's Name/Relationship (Type, Print) <b>LINDA ROSE/DAUGHTER</b>				
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6708 NORVIEW COURT, SPRINGFIELD, VIRGINIA 22152</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING DAVID MEML GDNS</b>		20c. Location - City or Town, State <b>JANUARY 5, 2004 FALLS CHURCH, VIRGINIA</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>						
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>ORGANIC BRAIN SYNDROME</b> Due to (or as a consequence of): b. <b>GOITER</b> Due to (or as a consequence of): c. <b>ARTHRITIS</b> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA		26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D35792</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 3, 2004</b>		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. SWAROOP G. RAO, 50 WEST EDMONSTON DRIVE, ROCKVILLE, MARYLAND 20852</b>							31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>	
	32. Registrar's Signature 							33. Registrar's Title <b>Sparks</b>	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01542

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Otto Graff				2. Date of Death Month Day Year January 5, 2004				3. Time of Death 2:54 PM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 152-20-9712		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 11, 1925		9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent				10a. State Tennessee		10b. County Washington		10c. City, Town or Location Johnson City	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1501 Strawberry Lane				10f. Zip Code 37604	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry Education				17. Father's Name (First, Middle, Last) Otto Graff, Sr.	
	18. Mother's Name (First, Middle, Maiden Surname) Clara Langweiler				19a. Informant's Name/Relationship (Type, Print) Raymond O. Graff/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4231 Charley Forest Street, Olney, Maryland 20832	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.				20c. Location - City or Town, State Bethesda, Maryland	
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M01353 Bethesda, Maryland 20814-3501				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GASTRIC CANCER	
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year	
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier [Signature] M.D.				29c. License number MD17000DS1616				29d. Date signed (Month, Day, Year) 01 05 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NELSON KALIL 18111 Prince Philip Drive #327, OLNEY, MD 20832				31. Date filed (Month, Day, Year) JAN 09 2004				32. Registrar's Signature [Signature]		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01543

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

Natasha Graves

2. Date of Death  
Month Day Year  
JANUARY 8, 2004

3. Time of Death  
1:32a M

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

579 96 1218

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

27 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

10/31/76

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Md

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

511 Harry Turman Drive

10f. Zip Code

20774

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Coustomer Service Resp.

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Janoff Graves

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Basemore

19a. Informant's Name/Relationship (Type, Print)

Sylvia Bazemore Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

511 Harry Turman Drive Upper Marlboro, Md

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Park

Date

01/12/04

20c. Location - City or Town, State

Riverdale, Md

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Snead Mortuary Service, P.A.  
1409 Fairlakes Pl Ste B Mitchellville, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Hypertensive cardiovascular disease

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
XX Yes 2 ☐ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Tasha L Zemrus MD*

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JANUARY 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tasha L Zemrus MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01544

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Fernando G. Garcia-Barbon

2. Date of Death

Month Day Year  
JAN 04 04 1000 M

3. Time of Death

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

584-40-7589

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 3, 1953

9. Birthplace (State or Foreign Country)

Cuba

Usual Residence of Decedent

10a. State

Puerto Rico

10b. County

N/A

10c. City, Town or Location

San Sebastian

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

HC1 Box 9386

10f. Zip Code

00685

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Cuban

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clinical Psychologist

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Angel Garcia-Barbon

18. Mother's Name (First, Middle, Maiden Sumame)

Victoria M. Moll

19a. Informant's Name/Relationship (Type, Print)

Maria G. Montigo (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

HC1 Box 9386, San Sebastian, Puerto Rico 00685

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cementerio Nueva De Jerusalem

Date

January 8, 2004

20c. Location - City or Town, State

Utuaado, Puerto Rico

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Rapp Funeral and Cremation Services

933 Gist Ave., Silver Spring, Md. 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

b. reoccurrence of non-small lung cancer

Due to (or as a consequence of):

c. interstitial lung disease secondary to

Due to (or as a consequence of):

PRESSA

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Deanna White MD

29c. License number

60953

29d. Date signed (Month, Day, Year)

01/04/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deanna White, MD 7600 Carroll Ave Takoma Park Md

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01545

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Iluminado N. Garcia</b>		2. Date of Death Month <b>January</b> Day <b>1</b> Year <b>2004</b>		3. Time of Death <b>12:15 a M</b>	
4a. Facility Name (If not institution, give street and number) <b>10414 Glenmore Drive</b>		4b. City, Town, or Location of Death <b>Adelphi</b>		4c. County of Death <b>Prince George's</b>	
5. Social Security Number <b>581-10-9983</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>March 1, 1931</b>	9. Birthplace (State or Foreign Country) <b>Puerto Rico</b>	
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Adelphi</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>10414 Glenmore Drive</b>		10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Puerto Rican</b>	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction Worker</b>		16b. Kind of Business/Industry <b>Construction</b>	
17. Father's Name (First, Middle, Last) <b>Mariano Garcia</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Carmen Nieves</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Martha R. Garcia Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10414 Glenmore Drive Adelphi, Maryland 20783</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Location - City or Town, State <b>Jan. 5, 2004 Silver Spring, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Prostate Cancer</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D 53829</b>		29d. Date signed (Month, Day, Year) <b>January 2, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kevin Shannon M.D. 7525 Greenway Center Dr. #205, Greenbelt, MD 20770</b>					
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature 			

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01546

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mauricio Guevarra</b>				2. Date of Death Month <b>January</b> Day <b>1</b> Year <b>2004</b>		3. Time of Death <b>4:05 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>None</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>0</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 1, 2004</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>12514 Epping Court</b>		10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Salvadoran</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>None</b> College (1-4 or 5+) <b>None</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Never Worked</b>		16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>Franklin Mauricio Guevarra</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Elvia Fuentes</b>		19a. Informant's Name/Relationship (Type, Print) <b>-Father</b> <b>Franklin Mauricio Guevarra</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12514 Epping Court, Silver Spring, MD 20906</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>		21. Signature of Funeral Service Licensee <b>Francis J. Collins Funeral Home Inc.</b>		22. Name and Address of Facility <b>500 University Blvd. W., Silver Spring, MD 20901</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Placental Abruption</b>		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Dr. Tamara Coates</b>		29c. License number <b>D43696</b>		29d. Date signed (Month, Day, Year) <b>1/2/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Tamara Coates 1500 Forest Glen Road Silver Spring MD 20910</b>		31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature <b>James S. Sparks</b>				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-5000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01547

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clarence F. Hall Sr.				2. Date of Death Month Day Year January 1 2004		3. Time of Death 1:30 pM	
	4a. Facility Name (If not institution, give street and number) Chesapeake Hospice House				4b. City, Town, or Location of Death Linthicum		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 212-16-4894		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) June 6 1919	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 29 W. Washington Street Apt. 209		10f. Zip Code 21401		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chief Cook		16b. Kind of Business/Industry US Naval Academy			
	17. Father's Name (First, Middle, Last) Frederick Hall				18. Mother's Name (First, Middle, Maiden Surname) Frances Johnson			
	19a. Informant's Name/Relationship (Type, Print) Pamela Harris (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 165808 Little Rock, AR 72216			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) Maryland Veteran Cemetery		20c. Location - City or Town, State Crownsville, Md.		20d. Date 1/8/04	
	21. Signature of Funeral Service Licensee Larry D. Reese M00483				22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic cancer Due to (or as a consequence of): b. liver metastasis Due to (or as a consequence of): c. colon cancer Due to (or as a consequence of): d.							
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown							
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)							
23d. Date of delivery Month Day Year								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Curis Harris MD				29c. License number D53306		29d. Date signed (Month, Day, Year) 1/6/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Curis Harris, MD 888 Bestgate Rd Ste 211 Annapolis MD 21401								
State Registrar	31. Date filed (Month, Day, Year) JAN 07 2004				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01548

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Audrey Deloris Harvey</b>			2. Date of Death Month Day Year <b>January 6, 2004</b>		3. Time of Death <b>11:35 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>18151 Garrett Highway</b>			4b. City, Town, or Location of Death <b>Oakland</b>		4c. County of Death <b>Garrett</b>	
Funeral Director	5. Social Security Number <b>214-36-6996</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar. 2, 1938</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Oakland</b>		10d. Inside City Limits <b>1 Yes 2 No</b>
	10e. Street and Number <b>18151 Garrett Highway</b>			10f. Zip Code <b>21550</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9th College (1-4 or 5+) Owner</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner</b>		16b. Kind of Business/Industry <b>Ceramic Shop</b>	
	17. Father's Name (First, Middle, Last) <b>Charles Niner</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Cora Bucklew</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Larson G. Harvey/husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18151 Garrett Highway, Oakland, Md. 21550</b>			
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Deer Park Cemetery</b>		Date <b>1/9/2004</b>		20c. Location - City or Town, State <b>Deer Park, Maryland</b>
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of): <b>b. Emphysema</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)</b>		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>	
24a. Was an autopsy performed? <b>1 Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>					
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b>		26. Place of Death (Check only one) Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>			
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29b. Signature and title of certifier 		29c. License number <b>D23979</b>		29d. Date signed (Month, Day, Year) <b>01/08/2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert A. Goralski, M.D. 311 N. Fourth St., Oakland, Md. 21550</b>							
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01549

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OLENA AUDREY HAHN

2. Date of Death

Month Day Year  
JANUARY 5, 2004

3. Time of Death

6:25 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

DENNETT ROAD MANOR NURSING HOME

4b. City, Town, or Location of Death

OAKLAND

4c. County of Death

GARRETT

5. Social Security Number

218-60-1508

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC 31, 1916

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

MT. LAKE PARK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

115 E STREET

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

FRANCES OBADIAH IDLEMAN

18. Mother's Name (First, Middle, Maiden Surname)

CYNTHIA CATHERINE MACKLEY

19a. Informant's Name/Relationship (Type, Print)

CYNTHIA CARR - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

120 O'BRIEN ST. MT. LAKE PARK, MD 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GARRETT MEMORIAL GARDS 1/8/04

Date

20c. Location - City or Town, State

OAKLAND, MARYLAND

21. Signature of Funeral Service Licensee



MO0167

22. Name and Address of Facility

P.O. BOX 243  
DURST FUNERAL HOME - OAKLAND, MD 2155023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

CA OF LUNG WITH METASTASIS

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

H26154

29d. Date signed (Month, Day, Year)

JANUARY 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. DANIEL MILLER, D.O. 69 WOLF ACRES DRIVE OAKLAND, MD 21550

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23e or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01550

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur Jackson Hanlin

2. Date of Death  
Month Day Year

Jan. 3 2004

3. Time of Death

0055 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

220-26-9609

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Oct. 18, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

567 Kings Run Road

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Military

16b. Kind of Business/Industry

US Air Force

17. Father's Name (First, Middle, Last)

Arthur Herman

Hanlin

18. Mother's Name (First, Middle, Maiden Surname)

Georgia

Uphold

19a. Informant's Name/Relationship (Type, Print)

Letha J. Hanlin/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

567 Kings Run Road, Oakland, Md. 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrett Co. Mem. Gdns. 1/6/2004

Date

20c. Location - City or Town, State

Oakland, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Stewart Funeral Home

32 S. Second St., Oakland, Md. 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Prostatic Cancer &amp; metastases month

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lasta. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

severe Anemia  
sleeping

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

DO3459

29d. Date signed (Month, Day, Year)

1/4/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. ESPINA, MD 902 Seton Drive, Cumberland, MD

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 05 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01551

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

James Minton Hadra

2. Date of Death

Month Day Year  
January 10, 2004

3. Time of Death

7:15 P M

4a. Facility Name (If not institution, give street and number)

Gunther Hotel

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

5. Social Security Number

463-44-5608

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

15-Sep-1932

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

11 West Main Street

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

professor

16b. Kind of Business/Industry

language department

17. Father's Name (First, Middle, Last)

Jack Ernest Hadra

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Louise Minton

19a. Informant's Name/Relationship (Type, Print)

Winifed Redick

estate executor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

54 Beall's Lane

Frostburg

Maryland

21532-

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory

Date

12-Jan-2004

20c. Location - City or Town, State

Cumberland Maryland

21. Signature of Funeral Service Licensee

*John R. Durst*

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Hypertensive Arteriosclerotic Cardiovascular Disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death ☐ Unknown

☐ Ectopic pregnancy

☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?  
☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
☒ Yes ☐ No

25. Was case referred to medical examiner?  
☒ Yes ☐ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☒ Other (Specify) at scene

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*J. LARON LOCKE, MD*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 11, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*J. LARON LOCKE, MD*

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 12 2004

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01552

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FLORENCE MODESTA HALE</b>				2. Date of Death Month <b>JAN</b> Day <b>4</b> Year <b>2004</b>		3. Time of Death <b>12:30 aM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>192-12-2317</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT 7 1922</b>	
	9. Birthplace (State or Foreign Country) <b>PA</b>		10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>GERMANTOWN</b>	
Usual Residence of Decedent								
10a. State <b>MD</b>			10b. County <b>MONTGOMERY</b>			10c. City, Town or Location <b>GERMANTOWN</b>		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number <b>18421 KINGSHILL ROAD</b>			10f. Zip Code <b>20874</b>		
10g. Citizen of What Country? <b>USA</b>			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>4</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REGISTERED NURSE</b>			16b. Kind of Business/Industry <b>HEALTH CARE</b>			17. Father's Name (First, Middle, Last) <b>CASIMIR KASABA</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>VERONICA MICHAELS</b>			19a. Informant's Name/Relationship (Type, Print) <b>PATRICIA HALE-SEGURA/DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6798 STONE MAPLE TERR., CENTERVILLE, VA 20121</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. OLIVET CEMET.</b>			20c. Location - City or Town, State <b>1/7/04 CARVERTON, PA</b>		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>HILTON FUNERAL HOME</b> <b>P.O. BOX 86, BARNESVILLE, MD 20838</b>			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Septic shock</b> Due to (or as a consequence of): <b>Klebsiella sepsis and fungemia</b> Due to (or as a consequence of): <b>Intraabdominal infection</b>		
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic renal failure</b> <b>Morbid obesity</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		
28b. Time of Injury <b>M</b>			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier MD			29c. License number <b>00054063</b>			29d. Date signed (Month, Day, Year) <b>01/04/2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Isabelle Healy MD - Shady Grove Hospital - Rockville - Maryland</b>								
31. Date filed (Month, Day, Year) <b>JAN - 6 2004</b>			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01553

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEANETTE B HEBDEN

2. Date of Death

JANUARY 2 2004

3. Time of Death

7:04 p M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

230-09-1747

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

8. Date of Birth (Month, Day, Year)

March 16, 1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Walkersville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

56 W. Frederick Street

10f. Zip Code

21793

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

State Department

17. Father's Name (First, Middle, Last)

Benjamin Franklin Nash

18. Mother's Name (First, Middle, Maiden Surname)

Lizzie Gouldman

19a. Informant's Name/Relationship (Type, Print)

Steven Balderson - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1204 Oakwood Drive, Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

1/6/2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Sharon Camille Clive

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure  
Aortic Stenosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M Tolino MD

29c. License number

M00051610

29d. Date signed (Month, Day, Year)

1-5-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1475 Tawney Ave, Suite 204, Frederick, MD 21702

31. Date filed (Month, Day, Year)

JAN - 6 2004

32. Registrar's Signature

B Spark

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #24aperaverbalG8282/25/04 Certificate of Death

Reg. No. 2004 01554

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Mary Elizabeth Hatter</b>			2. Date of Death Month Day Year <b>January 4, 2004</b>		3. Time of Death <b>4:10 P<sup>M</sup></b>
4a. Facility Name (If not institution, give street and number) <b>16932 Annandale Road</b>			4b. City, Town, or Location of Death <b>Emmitsburg</b>		4c. County of Death <b>Frederick</b>
5. Social Security Number <b>215-26-1887</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 13, 1919</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>	10c. City, Town or Location <b>Emmitsburg</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>16932 Annandale Road</b>			10f. Zip Code <b>21727</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>		16b. Kind of Business/Industry <b>Tailoring</b>
17. Father's Name (First, Middle, Last) <b>Earl Brown</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Mae Bush</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Loretta Blevins/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16932 Annandale Road, Emmitsburg, MD 21727</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Brown Cemetery</b>		20c. Location - City or Town, State <b>1/9/2004 Foxville, MD</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Stauffer Funeral Home, PA 104 E. Main Street, Thurmont, MD 21788</b>		

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter all disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>cardiopulmonary failure</b>			Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, cardiac valvular disease, peripheral vascular disease.</b>			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</b>		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number <b>D0058659</b>		29d. Date signed (Month, Day, Year) <b>1-6-04</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOE R. FERGUSON, III MD PO Box 190 Emmitsburg MD 21727</b>				

State  
Registrar

31. Date filed (Month, Day, Year) <b>JAN - 7 2004</b>	32. Registrar's Signature 
--	-------------------------------

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01555

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Mary Horne

2. Date of Death  
Month Day Year  
January 7 20043. Time of Death  
816 a M

4a. Facility Name (If not institution, give street and number)

110 Jefferson Road

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

577-52-2716

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

8. Date of Birth (Month, Day, Year)

May 19, 1914

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2521 Lisa Drive

10f. Zip Code

20601

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

John J. Friel

18. Mother's Name (First, Middle, Maiden Surname)

unavailable

19a. Informant's Name/Relationship (Type, Print)

Margaret Horne-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2521 Lisa Drive, Waldorf, Maryland 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery 01-12-2004

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

M01241

22. Name and Address of Facility

Huntt Funeral Home

P.O. Box 156, Waldorf, Maryland 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Positional asphyxia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

January 7, 2004

28b. Time of Injury

unknown

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

assisted living facility

28d. Describe how injury occurred

neck lodged between head and bedrail

28f. Location (Street and Number or Rural Route Number, City or Town, State)

110 Jefferson Rd, Waldorf, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tasha L Zemmes MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

January 8 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tasha L Zemmes M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

Klaus B. Speck

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01556

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Shirley Woodford Handley</b>		2. Date of Death Month Day Year <b>January 5, 2004</b>		3. Time of Death M <b>1430</b>	
4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>		4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>235-60-5881</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Dec. 25, 1935</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Olney</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>3801 Brooke Meadow Lane</b>		10f. Zip Code <b>20832</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Homemaker</b>		16. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Rodney Felton</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian V. Woodford</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Joseph A. Handley, Jr.- Spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3801 Brooke Meadow Lane Olney, MD 20832</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Crematory</b>		20c. Date <b>01/11/2004</b>	
20d. Location - City or Town, State <b>Baltimore, MD</b>		21. Signature of Funeral Service Licensee <i>Paul Bannen</i>			
22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home</b>		<b>11800 New Hampshire Ave. Silver Spring, MD 20904</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Anaphylaxis</b> Approximate Interval Between Onset and Death <b>1 hour</b>					
a. Due to (or as a consequence of): <b>Respiratory Failure</b> <b>1 hour</b>					
b. Due to (or as a consequence of): <b>Ovarian Cancer</b> <b>3 months</b>					
c. Due to (or as a consequence of): <b>Cardiomegaly</b> <b>years</b>					
d. <b>Cardiomegaly</b>					
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <i>Paul Bannen</i>		29c. License number <b>MD60335</b>		29d. Date signed (Month, Day, Year) <b>January 5, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Bannen, M.D. 1811 Prince Phillip Dr. #327 Olney, MD 20852</b>					
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature <i>Paul Bannen</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01557

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDITH HELFER</b>				2. Date of Death Month Day Year <b>JANUARY 1, 2004</b>		3. Time of Death <b>11:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HEBREW HOME OF GREATER WASHINGTON</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>091-14-8781</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>104</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12/23/1899</b>	
	9. Birthplace (State or Foreign Country) <b>RUSSIA</b>		10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>ROCKVILLE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>6036 LOGANWOOD DRIVE</b>		10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>CLERK</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK</b>		16b. Kind of Business/Industry <b>BAKERY</b>			
	17. Father's Name (First, Middle, Last) <b>JOSEPH GOLDSTEIN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LENA FINKELSON</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>HARRY PITT-SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6036 LOGANWOOD DRIVE, ROCKVILLE, MARYLAND 20852</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH EL CEMETERY</b>		Date <b>01/04/2004</b>		20c. Location - City or Town, State <b>PARAMUS, NEW JERSEY</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number <b>D24942</b>		29d. Date signed (Month, Day, Year) <b>JAN 2 2004</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GREGORY A COMPTON MD 6121 Montrose Rd Rockville MD</b>							
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01558

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Linda Lo Hsieh</b>				2. Date of Death Month <b>January</b> Day <b>3</b> , Year <b>2004</b>		3. Time of Death <b>9:33 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>17716 New Hampshire Ave.</b>				4b. City, Town, or Location of Death <b>Ashton</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>577-56-9680</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 15, 1918</b>	9. Birthplace (State or Foreign Country) <b>China</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Ashton</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>17716 New Hampshire Ave.</b>			10f. Zip Code <b>20861</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 Yrs.</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Artist</b>			16b. Kind of Business/Industry <b>Art</b>		
	17. Father's Name (First, Middle, Last) <b>S.H. Lo</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>F.C. Chang</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Bernardine Bowersox-Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17716 New Hampshire Ave. Ashton, MD 20861</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Crematory</b>		Date <b>01/09/2004</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <b>Brenda E. With</b>		22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home</b> <b>11800 New Hampshire Ave. Silver Spring, MD 20904</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cerebral Thrombosis</b>				Approximate Interval Between Onset and Death <b>2 Years</b>			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Atrial Fibrillation</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Dennis M. Hannon MD</b>		29c. License number <b>D23124</b>		29d. Date signed (Month, Day, Year) <b>January 7, 2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Dennis M. Hannon, M.D. 2901 Olney-Sandy Spring Rd. Olney, MD 20832</b>								
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature <b>Sparks</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01559

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PRISCILLA E. HYLE

2. Date of Death

Month Day Year  
JAN. 5, 2004

3. Time of Death

5:51 p<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGES

5. Social Security Number

579-22-7801

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MARCH 15, 1918

9. Birthplace (State or Foreign Country)

WASH. D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

HYATTSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2250 LEWISDALE DR.

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

EDWARD POST

18. Mother's Name (First, Middle, Maiden Surname)

MONA G. HUGHES

19a. Informant's Name/Relationship (Type, Print)

CHARLES J. HYLE/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2250 LEWISDALE DR., HYATTSVILLE, MD. 20737

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

1-6-2004

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers

M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.  
5801 CLEVELAND AVE., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. UROSEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DUODENAL ULCER, HYPERTENSION

HIATAL HERNIA

ESOPHAGITIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. S. Auja M.D. Attending

29c. License number

D62580

29d. Date signed (Month, Day, Year)

JAN. 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARMJIT S. AUJLA, M.D. 5632 ANNAPOLIS RD. #13, BLADENSBURG, MD. 20710

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01560

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Esther Rosella Hiser

2. Date of Death

Month Day Year  
JANUARY 16, 2004

3. Time of Death

10:50 a.m.

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

213-18-2818

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 1, 1919

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

701 Furnace Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Keyser Refractory

17. Father's Name (First, Middle, Last)

Samuel Harrison Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Bessie (DuMar) Lewis

19a. Informant's Name/Relationship (Type, Print)

Charlotte Felton daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Laurel Drive Wiley Ford WV 26767

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Scarpelli Funeral Home, PA

Date

1/19/2004

20c. Location - City or Town, State

Cresaptown

MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Scarpelli Funeral Home, PA  
108 Virginia Avenue, Cumberland, MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
3 WEEKSSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D36766

29d. Date signed (Month, Day, Year)

January 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vik Poonai M.D. 924 Seton Drive Cumberland, Maryland 21502

31. Date filed (Month, Day, Year)

JAN 22 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01561

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Quentin P. Ingram

2. Date of Death

January 02, 2004

3. Time of Death

2154 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

218-41-9690

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

9

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 17, 1994

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Frederick

10c. City, Town or Location

Mount Airy

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

14120 Peddicord Road

10f. Zip Code

21771

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Biracial

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
4th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

John Otha Ingram

18. Mother's Name (First, Middle, Maiden Surname)

Janet Lee Kates

19a. Informant's Name/Relationship (Type, Print)

Janet K. Ingram - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14120 Peddicord Road, Mt. Airy, Maryland 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Mem. Gardens 1/8/04

Date

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensed

Robert L. Williams

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home  
26401 Ridge Road, Damascus, Maryland

20872-0117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pulmonary hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. systemic adenovirus infection

Due to (or as a consequence of):

2 months

c. bone marrow transplantation

Due to (or as a consequence of):

3 months

d. acute myeloid leukemia

Due to (or as a consequence of):

6 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute renal failure, gastrointestinal bleeding, respiratory failure, hypotension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Sasha Gubser, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sasha Gubser, MD 600 N. Wolfe St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JAN - 7 2004

32. Registrar's Signature

Sasha Gubser

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item # 4a Cecil Co.  
1- State Registrar 1/8/04 rjw

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01562

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Bernice Applebaum Johnson</i>				2. Date of Death Month Day Year <i>January 1, 2004</i>		3. Time of Death <i>11:50A M</i>	
	4a. Facility Name (If not institution, give street and number) <i>3875 Telegraph Road</i>				4b. City, Town, or Location of Death <i>Elkton</i>		4c. County of Death <i>Cecil</i>	
Funeral Director	5. Social Security Number <i>019-26-6597</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>82</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>DEC. 16, 1921</i>	
	9. Birthplace (State or Foreign Country) <i>BOSTON, MA</i>		10a. State <i>Florida</i>		10b. County <i>Dade</i>		10c. City, Town or Location <i>Bay Harbour</i>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <i>10275 Collins Ave.</i>		10f. Zip Code <i>33154</i>	
	10g. Citizen of What Country? <i>U.S.A.</i>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Interior Designer</i>				16b. Kind of Business/Industry <i>Design</i>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Dr. Jacob Applebaum</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Dr. Rose Moskew</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Jane Cutler</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3875 Telegraph Rd, Elkton, MD 21921</i>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Sharon Mem. Park</i>		20c. Location - City or Town, State <i>Sharon, MA</i>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Schornberg Memorial Chap- 519 Philadelphia Pike, Wilton, DE 19809</i>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on line. Immediate Cause (Final disease or condition resulting in death) <i>a. ASCVD</i> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <i>years</i>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>							
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>GI disorder, endometrial cancer in remission</i> <i>psychiatric illness</i>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death Check only one Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Daughter's home</i>			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier <i>H Farkas, MD</i>				29c. License number <i>D15314</i>		29d. Date signed (Month, Day, Year) <i>Jan 2, 2004</i>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>H Farkas, MD Union Hospital, Elkton, MD 21921</i>				31. Date filed (Month, Day, Year) <i>JAN 08 2004</i>			
	32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01563

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Maxene E. Jubien</b>		2. Date of Death Month Day Year <b>January 2, 2004</b>		3. Time of Death <b>6:00am M</b>	
4a. Facility Name (If not institution, give street and number) <b>Wilson Health Care Center</b>		4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>273-22-7395</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Mar. 8, 1925</b>	9. Birthplace (State or Foreign Country) <b>Ohio</b>	
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>931 Wild Forest Drive</b>		10f. Zip Code <b>20879</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Aeronautics</b>	
17. Father's Name (First, Middle, Last) <b>Arlo Jones</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lela Perkins</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Donna Hedges (Sister)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>48 Flounder Drive, Sebring Florida 33875</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Quantico Nat'l Cem.</b>		20c. Location - City or Town, State <b>1/7/2004 Quantico, Virginia</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute myocardial infarction</b>					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease Cor pulmonale. Osteoporosis Anemia of chronic disease. Hypotension</b>					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
24. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>104115</b>		29d. Date signed (Month, Day, Year) <b>January 2, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>H. Robert Birschbach, MD 201 Russell Avenue, Gaithersburg, MD 20877</b>					
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>		32. Registrar's Signature <i>[Signature]</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01564

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH CARLTON JONES</b>				2. Date of Death Month <b>JAN</b> Day <b>05</b> Year <b>2004</b>		3. Time of Death <b>1:20 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>141-46-0661</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 26, 1952</b>	
	9. Birthplace (State or Foreign Country) <b>Florida</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2019 Hickory Hill Lane</b>		10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1981-2003</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Human Resources Manager</b>		16b. Kind of Business/Industry <b>U.S. Army</b>			
	17. Father's Name (First, Middle, Last) <b>Willie Jones</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jewel Mann</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>LaSonia F. Jones / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2019 Hickory Hill Lane, Silver Spring, MD 20906</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		Date <b>January 22 2004</b>		20c. Location - City or Town, State <b>Arlington, VA</b>	
	21. Signature of Funeral Service Licensee <i>Anne Parker</i>		22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>METASTATIC COLORECTAL CANCER</b>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)							
23d. Date of delivery Month Day Year								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day Year)								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Todd D. Gleeson</i>								
29c. License number <b>0101234404 (VA)</b>								
29d. Date signed (Month, Day, Year) <b>06 JAN 2004</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TODD D. GLEESON LT MC USNR</b> <b>NATIONAL NAVAL MEDICAL CENTER</b> <b>BETHESDA MD 20889-5600</b>								
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>								
32. Registrar's Signature <i>Benjamin B Sparks</i>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

State  
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2004 01565

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ellwood Ray Kirby</b>				2. Date of Death Month <b>January</b> Day <b>06</b> Year <b>2004</b>				3. Time of Death <b>11:45 AM</b> M	
	4a. Facility Name (If not institution, give street and number) <b>16808 Dutch Hollow Road</b>				4b. City, Town, or Location of Death <b>Mount Savage</b>				4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>217-14-4287</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>05-Sep-1922</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Mount Savage</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>16808 Dutch Hollow Road</b>				10f. Zip Code <b>21545-</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>custodian</b>				16b. Kind of Business/Industry <b>board of education</b>		
17. Father's Name (First, Middle, Last) <b>Harvey Kirby</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Bertha Smith</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Emma Kirby wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16808 Dutch Hollow Road Mount Savage Maryland 21545-</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Saint Patrick's Cemetery</b>				20c. Location - City or Town, State <b>09-Jan-2004 Mt. Savage Maryland</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Prostate Cancer</b>										
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)										
23d. Date of delivery Month Day Year										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day Year)										
28b. Time of Injury M										
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 										
29c. License number <b>D00C0478</b>										
29d. Date signed (Month, Day, Year) <b>11/6/04</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Afag Ahmed 625 Kent Ave. Suite 102 Cumberland, MD 21502</b>										
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01566

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) Okey Wesley Kenney		2. Date of Death Month Day Year JANUARY 13, 2004		3. Time of Death 00:05 a. M	
4a. Facility Name (If not institution, give street and number) Memorial Hospital		4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
5. Social Security Number 219-14-5559		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.	
8. Date of Birth (Month, Day, Year) 04/15/1924		9. Birthplace (State or Foreign Country) West Virginia			
10a. State WV		10b. County Mineral		10c. City, Town or Location Ridgeley	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number Route #3 Old Furnace Road		10f. Zip Code 26753	
10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1946	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 12	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Railroad		17. Father's Name (First, Middle, Last) Okey Thomas Golden Kenney	
18. Mother's Name (First, Middle, Maiden Surname) Daisy Wagner		19a. Informant's Name/Relationship (Type, Print) D. Karen Comer / daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1 Box 39, Wiley Ford, WV 26767	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory		20c. Location - City or Town, State Cumberland, MD	
21. Signature of Funeral Service Licensee <i>Robert C. Adams</i>		22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>CONGESTIVE HEART FAILURE</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <u>Years</u>	
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DEMENTIA, CEREBROVASCULAR Disease</u>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Shiv Khanna</i>	
29c. License number D0054004		29d. Date signed (Month, Day, Year) JANUARY 13, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIV KHANNA M.D. 1221 E. NATIONAL HIGHWAY CUMBERLAND, MARYLAND 21502	
31. Date filed (Month, Day, Year) JAN 13 2004		32. Registrar's Signature <i>Sparks</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01567

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virgil Victor Kidwell

2. Date of Death

Jan 4 2004

3. Time of Death

16 00 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

22347 Pondsville Road

4b. City, Town, or Location of Death

Smithsburg

4c. County of Death

Washington

5. Social Security Number

217-42-2290

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 20, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

22347 Pondsville Road

10f. Zip Code

21783

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Boiler Mechanic

16b. Kind of Business/Industry

Montgomery County  
Public Schools

17. Father's Name (First, Middle, Last)

Ernest A. Kidwell

18. Mother's Name (First, Middle, Maiden Surname)

Dolly R. Costello

19a. Informant's Name/Relationship (Type, Print)

Linda Kidwell/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22347 Pondsville Road/Smithsburg, Maryland 21783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Memorial Gardens

Date

Jan. 9, 2004

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Sharon Camille Cline

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.  
1621 Opossumtown Pike/Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Blunt Force trauma to Head.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to a immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

Jan 4, 2004

28b. Time of Injury

16 00 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Struck by Barrel of Fertilizer

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

22347 Pondsville Rd Smithsburg, MD 21783

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Edward W. Ditto III MD

29c. License number

70-1062

29d. Date signed (Month, Day, Year)

Jan 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward W. Ditto III MD

19, 011 Orchard Terrace Rd  
Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

JAN - 7 2004

32. Registrar's Signature

Benita Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01568

1- For State Registrar MEND#7perH1/7/04,BMW,McCo

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ELAINE A. KAPLAN</b>			2. Date of Death Month Day Year <b>JANUARY 4, 2004</b>		3. Time of Death <b>9:33 P. M</b>
4a. Facility Name (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>			4b. City, Town, or Location of Death <b>TAKOMA PARK</b>		4c. County of Death <b>MONTGOMERY</b>
5. Social Security Number <b>213-44-7484</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>MAY 24, 1945</b>	9. Birthplace (State or Foreign Country) <b>WASHINGTON, DC</b>	
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>SILVER SPRING</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>603 CHICHESTER LANE</b>			10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>UNITED STATES</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
17. Father's Name (First, Middle, Last) <b>ABRAHAM SUSSMAN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARY FUTTERMAN</b>		
19a. Informant's Name/Relationship (Type, Print) <b>KENNETH D. KAPLAN, HUSBAND</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>603 CHICHESTER LANE, SILVER SPRING, MD 20904</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NATIONAL CREMATORY</b>		20c. Location - City or Town, State <b>1/7/04 FALLS CHURCH, VA</b>	
21. Signature of Funeral Service Licensee <b>Donald C. Stottmeyer</b>			22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Malignant Lymphoma</b> Due to (or as a consequence of): a. <b>Malignant Lymphoma</b> b. c. d. Approximate Interval Between Onset and Death <b>6 months</b>					
23b. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Clara Chan</b>		29c. License number <b>D41828</b>		29d. Date signed (Month, Day, Year) <b>January 5, 2004</b>	
30. Name and address of person who contacted cause of death (Item 23a) (Type, Print) <b>CLARA CHAN, MD. 9801 Georgia Ave #337, Silver Spring, MD</b>					
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>		32. Registrar's Signature <b>Benjamin B. Spauld</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01569

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NORRIS CALVIN KILMON, SR.</b>				2. Date of Death Month Day Year <b>Jan. 13, 2004</b>		3. Time of Death <b>11:11 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Civista Medical Center</b>				4b. City, Town, or Location of Death <b>La Plata, MD</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>228-18-5211</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV. 29, 1915</b>	
	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>		10a. State <b>MARYLAND</b>		10b. County <b>CHARLES</b>		10c. City, Town or Location <b>WALDORF</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3006 GALLERY PLACE, APT. T-3</b>		10f. Zip Code <b>20602</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SAWMILL OPERATOR</b>		16b. Kind of Business/Industry <b>BAILEY LUMBER CO.</b>			
	17. Father's Name (First, Middle, Last) <b>ELLIS LEVI KILMON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>IDA ESTELLE BALDERSON</b>		19a. Informant's Name/Relationship (Type, Print) <b>VIRGINIA M. KILMON --WIFE</b>			
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3006 GALLERY PLACE, APT. T-3, WALDORF, MD 20602</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. PETERS CEMETERY</b>		20c. Location - City or Town, State <b>1-17-04 WALDORF, MARYLAND</b>	
	21. Signature of Funeral Service Licensee <b>M00479</b> <i>Michael D. [Signature]</i>		22. Name and Address of Facility <b>RAYMOND FUNERAL SERVICE, P.A.</b> <b>LA PLATA, MARYLAND 20646</b>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Chronic obstructive pulmonary disease</b> Due to (or as a consequence of): b. <b>renal failure</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D-22574</b>		29d. Date signed (Month, Day, Year) <b>1/14/04</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert T. Pace, MD 12070 Old Line Ctr., Suite 202, 210 Waldorf, MD 20602</b>		31. Date filed (Month, Day, Year) <b>JAN 22 2004</b>		32. Registrar's Signature <i>[Signature]</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01570

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CORA BRODES LEGATES

2. Date of Death

January 7 2004

3. Time of Death

2:02 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

217-12-4214

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 3, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

520 Kerr Avenue

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Hecht Company

17. Father's Name (First, Middle, Last)

John Henry Brodes

18. Mother's Name (First, Middle, Maiden Surname)

Edith Sopha Bryan

19a. Informant's Name/Relationship (Type, Print)

Mamie L. Phillips/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Sunset Blvd., Preston, MD 21655

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Junior Order Cem. 1/10/04

Date

20c. Location - City or Town, State

Preston, Maryland

21. Signature of Funeral Service Licensee

Christine M. Coale

22. Name and Address of Facility

P.O. Box 43, Federalsburg, MD  
Framptom Funeral Home, PA 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Renal Failure

Due to (or as a consequence of):

b. Dehydration

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an  
autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ OOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D0033255

29d. Date signed (Month, Day, Year)

1/8/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melinda Butler 215 Bloomingdale Ave Federalsburg MD 21632

31. Date filed (Month, Day, Year)

JAN - 8 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit cause.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01571

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Edna Jeanette Lutz</b>				2. Date of Death Month <b>January</b> Day <b>9</b> Year <b>2004</b>		3. Time of Death <b>1455</b>	
4a. Facility Name (If not institution, give street and number) <b>Ruxton Health of Denton</b>				4b. City, Town, or Location of Death <b>Denton</b>		4c. County of Death <b>Caroline</b>	
5. Social Security Number <b>218-20-9170</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>December 21, 1926</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
10a. State <b>Maryland</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Denton</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>316 South Third Street</b>				10f. Zip Code <b>21629</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 HS Grad</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Deputy Treasurer</b>		16b. Kind of Business/Industry <b>Government</b>	
17. Father's Name (First, Middle, Last) <b>Kemp Medford</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Mae Layton</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Leslie F. Lutz Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>316 South Third Street, Denton, Maryland 21629</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Capitol Crematory</b>		Date <b>1/13/04</b>		20c. Location - City or Town, State <b>Dover, Delaware</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629</b>			

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic lung carcinoma</b>		Approximate Interval Between Onset and Death <b>1 yr</b>
Due to (or as a consequence of):		
Due to (or as a consequence of):		
Due to (or as a consequence of):		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b> <b>Atrial fibrillation</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b> 28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No	
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
---	--

29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D35284</b>		29d. Date signed (Month, Day, Year) <b>1/9/04</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ANDREA ALLEN MD 2195 Washington St Easton MD 21601</b>					

31. Date filed (Month, Day, Year) <b>JAN 12 2004</b>		32. Registrar's Signature <i>[Signature]</i>	
---	--	---	--

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01572

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Constance Marguerite Loan

2. Date of Death

January 10, 2004

3. Time of Death

5:35 PM

4a. Facility Name (If not institution, give street and number)

1804 Severn Grove Road

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

113-26-0466

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 3, 1903

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1804 Severn Grove Road

10f. Zip Code

21401

10g. Citizen of What Country?

United Kingdom

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Practical Nurse

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

William Loan

18. Mother's Name (First, Middle, Maiden Surname)

Grace Rhodes

19a. Informant's Name/Relationship (Type, Print)

Bill Buck/nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1804 Severn Grove Road Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

1/13/2004

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Todd E. Miller

22. Name and Address of Facility

John M. Taylor Funeral Home

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brain Stem infarction  
Due to (or as a consequence of):Approximate Interval Between Onset and Death  
4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerosis  
Due to (or as a consequence of):

50 years

c. Advanced Age  
Due to (or as a consequence of):

100 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Richard I. Hochman, MD

29c. License number

D05192

29d. Date signed (Month, Day, Year)

01/12/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard I. Hochman, MD 224 Wardour Drive, Annapolis Md. 21401

31. Date filed (Month, Day, Year)

JAN 14 2004

32. Registrar's Signature

Kara B. Jones

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


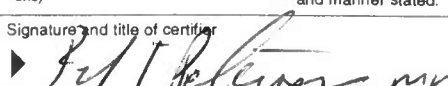
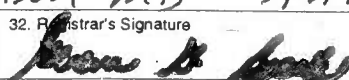
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01573

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rebecca Jordan Lidard</b>			2. Date of Death Month <b>January</b> Day <b>5</b> Year <b>2004</b>			3. Time of Death <b>11:30 a.</b>			
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>			4b. City, Town, or Location of Death <b>Annapolis</b>			4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>225-84-3769</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>49</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 18, 1954</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3213 Black Walnut Drive</b>				10f. Zip Code <b>21403</b>		10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Territory Manager</b>			16b. Kind of Business/Industry <b>Publishing</b>			
17. Father's Name (First, Middle, Last) <b>Henry P. Jordan</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>June Deyson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Gary M. Lidard (Husband)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3213 Black Walnut Drive Annapolis, Maryland 21403</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bestgate Memorial Park</b>			Date <b>Jan. 8, 2004</b>		20c. Location - City or Town, State <b>Annapolis, Maryland</b>		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>M00982 814 Bestgate Rd. Annapolis, Maryland 21401</b>		22. Name and Address of Facility <b>Adams Funeral &amp; Memorial Care</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Amyotrophic lateral sclerosis</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>7 Yrs</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>pneumonia</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 			29c. License number <b>D24804</b>			29d. Date signed (Month, Day, Year) <b>1-05-2004</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert J Peterson MD AAMS Annapolis Md 21401</b>										
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0036  
permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01574

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLET CELESTE LEE

2. Date of Death

January 5, 2004

3. Time of Death

6:40A. M

4a. Facility Name (If not institution, give street and number)

Cuppett Weeks Nursing Home

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

215-80-7995

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

OCT 30, 1912

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

223 MASON SCHOOL ROAD

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JUDSON

FOSTER

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

JORDAN

19a. Informant's Name/Relationship (Type, Print)

SHIRLEY COSNER - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

266 MASON SCHOOL ROAD OAKLAND, MD 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GARRETT MEMORIAL GARDS. 1/7/04

Date

20c. Location - City or Town, State

OAKLAND, MARYLAND

21. Signature of Funeral Service Licensee

MO0167

22. Name and Address of Facility

P.O. BOX 243  
DURST FUNERAL HOME - OAKLAND, MD 2155023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Coronary Artery Disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 Week

Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0033464

29d. Date signed (Month, Day, Year)

January 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert M. Coughlin, M.D. PO Box 8, Eglon, WV 26716

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01575

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ola Augustine Lancaster

2. Date of Death

January 6 2004

Day Year

3. Time of Death

7:00 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Vindobona Nursing Home

4b. City, Town, or Location of Death

Braddock Heights

4c. County of Death

Frederick

5. Social Security Number

225-03-4221

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 18 1916

9. Birthplace (State or Foreign Country)

Cadiz, Kentucky

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

507 9th Avenue

10f. Zip Code

21716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

B&amp;O Chessie

17. Father's Name (First, Middle, Last)

Wadford Lancaster

18. Mother's Name (First, Middle, Maiden Surname)

Seronia Vanzant

19a. Informant's Name/Relationship (Type, Print)

Dan K. Lancaster, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4115 Burkittsville Road, Knoxville, MD 21758

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Park Heights Cemetery 1/9/04

Date

20c. Location - City or Town, State

Brunswick, MD

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home  
100 Petersville Road, Brunswick, MD 2171623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Pneumonia*  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death*days*Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Dementia, Stroke*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D47169

29d. Date signed (Month, Day, Year)

1-8-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ho, CHAN-HING, M.D. 610 9th Ave, Brunswick, MD 21716

State  
Registrar

31. Date filed (Month, Day, Year)

JAN - 9 2004

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01576

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carol Jean Lane

2. Date of Death

1-3-04

Day Year

3. Time of Death

8:15 P. M

4a. Facility Name (If not institution, give street and number)

Villa Rosa Nursing Home

4b. City, Town, or Location of Death

Mitchellville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-18-4055

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

4-2-1921

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5815 Walton Rd.

10f. Zip Code

20817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Chapin Bauman

18. Mother's Name (First, Middle, Maiden Surname)

Mary Agnes McGarraghy

19a. Informant's Name/Relationship (Type, Print)

David Lane - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8965-C Early April Way, Columbia, MD 21046

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven

Date

1-7-04

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi F. H.  
11800 New Hampshire Ave., Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b. multiple cerebrovascular accidents

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

48 hours

Several months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

senile dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D22780

29d. Date signed (Month, Day, Year)

1-5-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter M Schisler 7500 Greenway Ctr. Dr. Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01577

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marion Patricia LaTendresse

2. Date of Death

January 3, 2004

3. Time of Death

6:00 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7620 Old Georgetown Road, #210

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

213-56-8880

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

March 5, 1922

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7620 Old Georgetown Road, #210

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

-

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward Joseph Hanrahan

18. Mother's Name (First, Middle, Maiden Surname)

Marion Gorman

19a. Informant's Name/Relationship (Type, Print)

T. Lorraine LaTendresse/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4719 Wyaconda Road, Rockville, Maryland 20852-2439

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven

Cemetery

Date

January 6,

2004

20c. Location - City or Town, State

Silver Spring,

Maryland

21. Signature of Funeral Service Licensee

MO0689

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue,

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

a. Late effects of Cerebral Vascular Accident

Due to (or as a consequence of):

T-cell Lymphoma

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recurrent Aspiration Pneumonia

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an

autopsy

performed?

☐ Yes ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

☐ Yes ☐ No

25. Was case referred to medical

examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

Susan J. Miller

29c. License number

D35579

29d. Date signed (Month, Day, Year)

January 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan J. Miller, M.D. 6844 Tulip Hill Terrace, Bethesda, Maryland 20816

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, a Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01578

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LIONEL Z. LEWIS

2. Date of Death  
Month Day Year  
JANUARY 2, 20043. Time of Death  
6:35 a M

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

080-32-7189

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
03/21/1929

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND MONTGOMERY

10b. County

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10921 INWOOD AVENUE #206

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

MARX

LEWIS

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE

WALKER

19a. Informant's Name/Relationship (Type, Print)

JAMES WALKER/ COUSIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3953 SANDRINGHAM CT. MYRTLE BEACH SC 29528

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MT. LEBANON CEMETERY

Date

01/04/2004

20c. Location - City or Town, State

ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee

Amanda Ludwig

22. Name and Address of Facility

DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC.  
1170 ROCKVILLE PIKE, ROCKVILLE, MD 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC PROSTATE CANCER

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
YEARSSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

1 MONTH

c. CEREBRAL PALSY

Due to (or as a consequence of):

YEARS

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Amanda Ludwig MD

29c. License number

D35635

29d. Date signed (Month, Day, Year)

JANUARY 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH KAPLAN, M.D., 18111 PRINCE PHILIP DR., OLNEY, MARYLAND 20837

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01579

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Susan B. Lipuma

2. Date of Death

1-6-2004

Day Year

3. Time of Death

11:09 A. M

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

075-14-0357

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1-24-22

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1204 Schindler Dr.

10f. Zip Code

20903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Andrea Bongianini

18. Mother's Name (First, Middle, Maiden Sumame)

Francesca DeVico

19a. Informant's Name/Relationship (Type, Print)

Anthony C. Lipuma - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1605 Maydale Dr. Silver Spring, MD 20905

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Crem.

Date

1-10-04

20c. Location - City or Town, State

Bladensburg, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi F. H.

11800 New Hampshire Ave., Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Cardiac arrest

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Hypertension

b. Due to (or as a consequence of):

Respiratory infection

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

59775

29d. Date signed (Month, Day, Year)

1/7/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zaih Shanavas M.D., 10801 Lockwood Dr. #20, Silver Spring, MD 20901

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01580

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cheng-Wen Liu

2. Date of Death

January 3, 2004

3. Time of Death

1:55 AM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

100-62-5837

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 27, 1931

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

New York

10b. County

Nassau

10c. City, Town or Location

Westbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

455 Newton Street

10f. Zip Code

11590

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shipping Clerk

16b. Kind of Business/Industry

Sign Company

17. Father's Name (First, Middle, Last)

Ji-Quang Liu

18. Mother's Name (First, Middle, Maiden Surname)

Wong

19a. Informant's Name/Relationship (Type, Print)

Anna Chao Liu/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11801 Rockville Pike, # 802, Rockville, MD. 20852

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

1/7/04

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Glioblastoma Multiforme

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Outpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D56652

29d. Date signed (Month, Day, Year)

January 3, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Poterrett, MD 9901 Medical Center Dr. Rockville, MD

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

James B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01581

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine Dargan Lloyd</b>				2. Date of Death Month Day Year <b>January 8, 2004</b>		3. Time of Death <b>5:00 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>8503 Victory Lane</b>				4b. City, Town, or Location of Death <b>Potomac</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>217-46-5528</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 18, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10a. State <b>Md.</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8503 Victory Lane</b>		10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Andrew Dargan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bridget Price</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>(daughter) Catherine Ann Lloyd Grundmayer</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11725 Happy Choice Lane, Gaithersburg, Md. 20878</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		20c. Location - City or Town, State <b>Washington, D.C.</b>		20d. Date <b>Jan. 12, 2004</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, Md.</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cerebrovascular Accident</b>				Approximate Interval Between Onset and Death <b>4 weeks</b>			
To Be Completed by Physician/Medical Examiner	23b. Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Atrial Fibrillation</b>				Years			
	23c. Due to (or as a consequence of): <b>Atherosclerotic Cardiovascular Disease</b>				Years			
To Be Completed by Physician/Medical Examiner	23d. Due to (or as a consequence of): <b>Hypertension</b>				Years			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D32033</b>		29d. Date signed (Month, Day, Year) <b>January 8, 2004</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peter G. Hamm, M.D., 5530 Wisconsin Avenue, #930, Chevy Chase, Md. 20815</b>			
	31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


2004 01582

## Certificate of Death

Reg. No.

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Edythe S. Lockhart</b>				2. Date of Death Month Day Year <b>January 3 2004</b>		3. Time of Death <b>9:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Wilson Health Care Center</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>125-09-5044</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 10, 1921</b>	
9. Birthplace (State or Foreign Country) <b>Illinois</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>407 Russell Avenue Apt. 207</b>				10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>		16b. Kind of Business/Industry <b>Textile</b>	
17. Father's Name (First, Middle, Last) <b>George Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Zimmer</b>			
19a. Informant's Name/Relationship (Type, Print) <b>William R. Lockhart / Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>407 Russell Avenue Apt. 207 Gaithersburg, MD 20877</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>Jan. 5, 2004</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b> Approximate Interval Between Onset and Death <b>2 weeks</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Alzheimer's Dementia</b> <b>5 years</b> a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>041794</b>		29d. Date signed (Month, Day, Year) <b>January 5, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P. Callahan-Lyon, mo 911 Russell Ave Gaithersburg, MD 20879</b>							
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01583

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD L. MCKELVEY				2. Date of Death Month Day Year January 7, 2004				3. Time of Death 0700 M		
	4a. Facility Name (If not institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death Easton				4c. County of Death Talbot		
Funeral Director	5. Social Security Number 280-26-8060		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) FEB 25 1933		9. Birthplace (State or Foreign Country) OHIO		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MD		10b. County TALBOT		10c. City, Town or Location EASTON				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2 BAKER STREET				10f. Zip Code 21601		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) POSTMASTER			16b. Kind of Business/Industry U.S. POSTAL SERVICE			
	17. Father's Name (First, Middle, Last) JOSEPH PETER MCKELVEY					18. Mother's Name (First, Middle, Maiden Surname) MARTHA CHARLESWORTH					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MARILYN L. MCKELVEY/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 BAKER STREET, EASTON, MD 21601						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR 1-8-2004		20c. Location - City or Town, State STEVENSVILLE, MD				
	21. Signature of Funeral Service Licensee JOHN R. MERLESON				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ISCHEMIC HEART DISEASE</u> Due to (or as a consequence of): b. <u>DIABETES</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death YEARS.										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and Title of certifier Scott D. Friedman				29c. License number D23962		29d. Date signed (Month, Day, Year) 1.08.04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCOTT D. FRIEDMAN M.D. 522 IDLEWILD AVE EASTON, MD 21601											
31. Date filed (Month, Day, Year) JAN 09 2004				32. Registrar's Signature Scott D. Friedman							

Donald L. McKelvey  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01584

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THOMAS SAMUEL MAYTON, JR</b>		2. Date of Death Month <b>JAN</b> Day <b>5<sup>th</sup></b> Year <b>2004</b>		3. Time of Death <b>08:41 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>HARFORD MEMORIAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>HARFORD</b>		4c. County of Death <b>HARFORD</b>
Funeral Director	5. Social Security Number <b>224-72-8313</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Feb. 18, 1951</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Cecil</b>
	10c. City, Town or Location <b>Port Deposit</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>1379 Belvidere Road</b>		10f. Zip Code <b>21904</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) Twelve Years</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>York Building Products Port Deposit, Maryland</b>		
	17. Father's Name (First, Middle, Last) <b>Thomas Samuel Mayton</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Cora Lee Daniels</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Ruth Ann Mayton (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1379 Belvidere Road, Port Deposit, Maryland 21904</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris &amp; Co., Inc.</b>		20c. Location - City or Town, State <b>West Chester, Pennsylvania</b>
	21. Signature of Funeral Service Licensee <b>Thomas H. Patterson, Sr.</b>		22. Name and Address of Facility <b>Lee A. Patterson &amp; Son Funeral Home, P.A. Perryville, Maryland 21903-0766</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)
	23d. Date of delivery Month Day Year				
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	23h. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	23i. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	23j. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	23k. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>James P. ... M.D.</b>		
	29c. License number <b>021809</b>		29d. Date signed (Month, Day, Year) <b>JAN 5<sup>th</sup> 2004</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>46 PRABHU M.D. 2336 YORK RD TIMONION MD 21093.</b>				
	31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>		32. Registrar's Signature <b>James P. ...</b>		
	State Registrar				

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01585

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth H. McMaster

2. Date of Death

January 2, 2004

3. Time of Death

1:52 P M

4a. Facility Name (If not institution, give street and number)

Calvert Manor Healthcare Ctr.

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

219-10-8807

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9-27-1906

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1881 Telegraph Road

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Chemical

17. Father's Name (First, Middle, Last)

William D. Hindman

18. Mother's Name (First, Middle, Maiden Surname)

Mabelle Straw

19a. Informant's Name/Relationship (Type, Print)

William C. McMaster, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Hoanhoustraat 86 9080 Beervele Belgium

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New London Presbyterian Church Cemetery

Date

1-8-2004

20c. Location - City or Town, State

New London, PA

21. Signature of Funeral Service Licensee

Edward L. Collins

22. Name and Address of Facility

86 Pine St, Oxford PA 19363  
Edward L. Collins Funeral Home, Inc.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. ASPIRATION PNEUMONITIS

Due to (or as a consequence of):

c. PROGRESSIVE DEMENTIA

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rodney Donaham

29c. License number

H-0058419

29d. Date signed (Month, Day, Year)

JANUARY 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RODNEY DONAHAM, D.O. 1881 TELEGRAPH ROAD RISING SUN MD 21911

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

K. B. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01586

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT HARRIS MURPHY

2. Date of Death

01 01 2004

3. Time of Death

23:46 M

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SAVILSBURG

4c. County of Death

Nicomino

Funeral  
Director

5. Social Security Number

080-03-1777

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JULY 20, 1920

9. Birthplace (State or Foreign Country)

BRONX, NY

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

REHOBOTH BEACH

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

50 BAY REACH, PINE BAY

10f. Zip Code

19971

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

BUSINESS ACCOUNTING

17. Father's Name (First, Middle, Last)

ARTHUR G. MURPHY

18. Mother's Name (First, Middle, Maiden Surname)

ETHEL HARRIS

19a. Informant's Name/Relationship (Type, Print)

ANN D. MURPHY /WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

50 BAY REACH DRIVE, PINE BAY, REHOBOTH BEACH, DE 19971

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematorium, or other place)

EASTERN SHORE  
CREMATORIUM

Date

01/05/04

20c. Location - City or Town, State

LEWES, DELAWARE

21. Signature of Funeral Service Licensee

Moo866

22. Name and Address of Facility

PARSELL FUNERAL HOMES & CREMATORIUM  
1449 KINGS HIGHWAY, LEWES, DE 19958

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE ORGAN FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY BYPASS SURGERY

Due to (or as a consequence of):

3 weeks

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

years

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy performed?  
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death Check on one

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0053551

29d. Date signed (Month, Day, Year)

1-02-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Todd, M.D. 100 E. PATIOTT ST SAVILSBURG MD

31. Date filed (Month, Day, Year)

JAN 05 2004

32. Registrar's Signature

Sparks

State  
Registrar

Murphy Robert 080-03-1777

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01587

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE P. MAJORS

2. Date of Death

January 02 2004

3. Time of Death

19:55 PM

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

213-14-1527

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-24-1919

9. Birthplace (State or Foreign Country)

SALISBURY

Usual Residence of Decedent

10a. State

MD

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

931 E. CHURCH STREET

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

RAYMOND J. PARSONS

18. Mother's Name (First, Middle, Maiden Surname)

STELLA WEST

19a. Informant's Name/Relationship (Type, Print)

WILLIAM J. MAJORS, JR. - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27499 MT. VERNON ROAD, PRINCESS ANNE, MARYLAND 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARSONS CEMETERY

Date

01-07-04

20c. Location - City or Town, State

SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee

Denise S. Kelly

22. Name and Address of Facility

BOUNDS FUNERAL HOME, INC.  
705 EAST MAIN STREET, SALISBURY, MARYLAND 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

year  
year  
year  
year

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Robins

29c. License number

028349

29d. Date signed (Month, Day, Year)

1/5/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS, M.D. 100 E. CARROLL ST. SALISBURY MD

31. Date filed (Month, Day, Year)

JAN 05 2004

32. Registrar's Signature

Denise S. Kelly

State  
Registrar

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01588

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES McCaffrey</b>		2. Date of Death Month <b>JANUARY</b> Day <b>3</b> Year <b>2004</b>		3. Time of Death <b>0030</b> M
	4a. Facility Name (If not institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>
Funeral Director	5. Social Security Number <b>053-24-2364</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>FEB. 2, 1930</b>	9. Birthplace (State or Foreign Country) <b>NEW YORK</b>
	Usual Residence of Decedent				
10a. State <b>DELAWARE</b>		10b. County <b>SUSSEX</b>	10c. City, Town or Location <b>SELBYVILLE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>33 YOLANDA STREET</b>		10f. Zip Code <b>19975</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1947-49</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SAND HOG</b>	
16b. Kind of Business/Industry <b>PUBLIC UTILITIES</b>		17. Father's Name (First, Middle, Last) <b>TERRENCE McCaffrey</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ANNE McDONNELL</b>	
19a. Informant's Name/Relationship (Type, Print) <b>EILEEN McCaffrey/WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>33 YOLANDA STREET, SELBYVILLE, DELAWARE 19975</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GATE OF HEAVEN</b>		20c. Location - City or Town, State <b>1/7/04 DAGSBORO, DELAWARE</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CAD</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>ASCVD</b>		23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Date of death Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23a. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier 		29c. License number <b>028912</b>		29d. Date signed (Month, Day, Year) <b>1/4/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DENNIS CHODNICKI, M.D., HEALTHWAY DRIVE, BERLIN, MD 21811</b>					
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01589

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Melvin Henry Miller</b>				2. Date of Death Month Day Year <b>JANUARY 8 2004</b>		3. Time of Death <b>1715<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>THE MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>	
Funeral Director	5. Social Security Number <b>215-05-1286</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 14, 1920</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Denton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>280 Camp Rd Homestead Manor Rm 213</b>				10f. Zip Code <b>21629</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-1947</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>chief warehouse manager</b>		16b. Kind of Business/Industry <b>Government</b>		
17. Father's Name (First, Middle, Last) <b>John Miller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Bollman</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Helen C. Poole sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6051 Pleasant St Zephyrhills, FL 33542</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Eastern Shore Veteran Cemetery</b>		Date <b>01/14/2004</b>		20c. Location - City or Town, State <b>Hurlock, Maryland</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fleegle and Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Renal failure</b> <b>dehydration</b>								Approximate Interval Between Onset and Death
23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)								23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>probable ischemic colitis</b> <b>Lower gastrointestinal bleed</b> <b>malnutrition</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>055484</b>		29d. Date signed (Month, Day, Year) <b>1-9-2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Haiou Laura Jin 219 S. Washington St Easton, Maryland 21601</b>								
31. Date filed (Month, Day, Year) <b>JAN 12 2004</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01590

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Daniel McMaster

2. Date of Death  
Month Day Year

January 10, 2004

3. Time of Death  
838 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

179-24-6445

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

June 4, 1932

9. Birthplace (State or Foreign  
Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland Anne Arundel

10b. County

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1221 Madison Street

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1950-  
197013. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Electronic Engineer

16b. Kind of Business/Industry

Defense Contractor

17. Father's Name (First, Middle, Last)

Edward McMaster

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Doyle

19a. Informant's Name/Relationship (Type, Print)

Kimberly Heskett / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

709 Willow Tree Drive Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hillcrest Mem. Cem.

Date

1/15/2004

20c. Location - City or Town, State

Annapolis, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Congestive Heart Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
4 yearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Pulmonary Hypertension

Due to (or as a consequence of):

4 years

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D19838

29d. Date signed (Month, Day, Year)

1/11/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart E. Selonick, MD 900 Bestgate Road Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JAN 14 2004

32. Registrar's Signature

Stuart E. Selonick

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01591

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles G. Meador Jr.

2. Date of Death

January 10, 2004

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

12619 Buckingham Drive

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

225-38-4060

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 16, 1935

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12619 Buckingham Drive

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: '54-'6213. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Plumber Local #5

17. Father's Name (First, Middle, Last)

Charlie G. Meador, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Foster

19a. Informant's Name/Relationship (Type, Print)

Mary Lou Meador/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12619 Buckingham Drive Bowie, MD 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MD Veterans Cemetery

Date

01/12/2004

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home

16000 Annapolis Road Bowie, MD 20715

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify) NA

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular disease  
Hypothyroidism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

0001285

29d. Date signed (Month, Day, Year)

1.12.04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HASSAN A. MOLAVI, MD 6005 Landover Rd Chevy Chase MD 20785

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 12 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01592

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Joseph Gerard McMahon</b>		2. Date of Death Month Day Year <b>January 9, 2004</b>		3. Time of Death <b>12:15 A<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>1628 Angus Court</b>		4b. City, Town, or Location of Death <b>Crofton</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>051-26-5869</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 17, 1934</b>	9. Birthplace (State or Foreign Country) <b>New York, NY</b>	
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Crofton</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1628 Angus Court</b>		10f. Zip Code <b>21114</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>'56-'62</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Manager</b>		16b. Kind of Business/Industry <b>Hotel</b>	
17. Father's Name (First, Middle, Last) <b>Joseph Gerald McMahon, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes Carroll</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Katherine E. McMahon/ Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1628 Angus Court Crofton, MD 21114</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Huntt Crematory</b>		20c. Location - City or Town, State <b>Waldorf, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Congestive Heart Failure (Rt heart)</b> a. Due to (or as a consequence of): <b>Stroke</b> b. Due to (or as a consequence of): <b>Diabetes</b> c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>3-4 yrs</b>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D44838</b>		29d. Date signed (Month, Day, Year) <b>1-9-04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SUSAN KRIEGER MD 2191 Defense Hwy Crofton, MD 21114</b>					
31. Date filed (Month, Day, Year) <b>JAN 12 2004</b>		32. Registrar's Signature 			

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01593

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, this Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, this Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Anne M. Mulrean</b>		2. Date of Death Month <b>January</b> Day <b>11</b> Year <b>2004</b>		3. Time of Death <b>8:00 A<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>061-09-8936</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 27, 1909</b>
9. Birthplace (State or Foreign Country) <b>New York</b>		Usual Residence of Decedent			
10a. State <b>Maryland</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Edgewater</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>439 Poplar Leaf Drive</b>		10f. Zip Code <b>21037</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	
16b. Kind of Business/Industry <b>Home</b>		17. Father's Name (First, Middle, Last) <b>Patrick Cryan</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen McNerney</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Stephen Mulrean/ Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>27 Wheeler Place, West Nyack, NY 10994</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calvary Cemetery</b>		20c. Location - City or Town, State <b>1-13-04 Queens, New York</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Sepsis of unclear etiology</b>		Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>2 days</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):			
Due to (or as a consequence of):		Due to (or as a consequence of):			
Due to (or as a consequence of):		Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D48101</b>	
29d. Date signed (Month, Day, Year) <b>January 11, 2004</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Donna Chambers MD 2002 Medical Parkway Suite 350 Annapolis MD 21401</b>					
31. Date filed (Month, Day, Year) <b>JAN 12 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2004 01594

1- For State Registrar

Physician / Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Mary Frances Mason				2. Date of Death Month Day Year January 4, 2004		3. Time of Death 4:25 P M	
4a. Facility Name (If not institution, give street and number) Ginger Cove Health Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
5. Social Security Number 163-16-3162		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 5, 1920	9. Birthplace (State or Foreign Country) Pennsylvania
Usual Residence of Decedent							
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 4000 River Crescent Drive				10f. Zip Code 21401		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W. II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Medical	
17. Father's Name (First, Middle, Last) Francis McGerty				18. Mother's Name (First, Middle, Maiden Surname) Agnes Rudden			
19a. Informant's Name/Relationship (Type, Print) Bert A. Mason/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Severn River Rd., Severna Park, MD 21146			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Ambrose Cemetery		Date 1-7-04		20c. Location - City or Town, State Cresaptown, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Dementia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Years							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes Mellitus</u>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D17965		29d. Date signed (Month, Day, Year) 1/5/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Friend 205 Ridgely Ave. Annapolis, Md. 21401							
31. Date filed (Month, Day, Year) JAN 06 2004				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01595

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruby E. Merryman</b>				2. Date of Death Month Day Year <b>January 6, 2004</b>		3. Time of Death <b>10:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Joseph Ritchey Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>246-22-2971</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 12, 1918</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>713 Maiden Choice Lane Apt. 1411</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Typesetter Specialist</b>			16b. Kind of Business/Industry <b>Printing</b>		
	17. Father's Name (First, Middle, Last) <b>Charles Colston McNeil</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosie Viola Triplett</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Rev. Ray Blanset/ Son-in-Law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>306 Meares Court, Annapolis, Maryland 21401</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park Cemetery &amp; Mausoleum</b>		Date <b>1/9/2004</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Colon Cancer with metastasis</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number <b>D 14383</b>		29d. Date signed (Month, Day, Year) <b>1/06/04</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Harold C Standiford MD Joseph Ritchey Hospice</b>								
31. Date filed (Month, Day, Year) <b>JAN 08 2004</b>		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01596

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary G. Marshall</b>				2. Date of Death Month Day Year <b>January 8, 2004</b>		3. Time of Death <b>8:13 P M</b>	
	4a. Facility Name (If not institution, give street and number) <b>2900 Shipmaster Way, #304</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>220-16-9098</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 17, 1927</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>2900 Shipmaster Way, 304</b>		10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>			
	17. Father's Name (First, Middle, Last) <b>Ernest Goddard, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Brandt</b>		19a. Informant's Name/Relationship (Type, Print) <b>Marie M. Krause/ Daughter</b>			
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>427 Edgemere Drive, Annapolis, MD 21403</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Our Lady of Sorrows</b>		20c. Location - City or Town, State <b>West River, MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>George P. Kalas Funeral Home</b> <b>2973 Solomons Island Rd. Edgewater, MD 21037</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>multiple myeloma</b>			
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
	24. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Date of Injury (Month, Day Year)		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D19838</b>		29d. Date signed (Month, Day, Year) <b>1/9/2004</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stuart E. Selonich, MD</b>		31. Date filed (Month, Day, Year) <b>JAN 12 2004</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item #19a per Informant 6826 2/17/04 LBS  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2004 01597

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Melva Pearl McKenzie</b>				2. Date of Death Month <b>January</b> Day <b>1</b> Year <b>2004</b>		3. Time of Death <b>5:00 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Goodwill Mennonite Home</b>				4b. City, Town, or Location of Death <b>Grantsville</b>		4c. County of Death <b>Garrett</b>	
Funeral Director	5. Social Security Number <b>220-40-1125</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 30, 1936</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Grantsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>1025 Springs Road</b>		10f. Zip Code <b>21536</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 th</b> College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>James Bittinger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Della Hoover</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Edward J. McKenzie</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1025 Springs Rd., Grantsville, MD 21536</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Grantsville Cemetery Jan 4, 2004</b>		20c. Location - City or Town, State <b>Grantsville, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIAC ARREST</b> Due to (or as a consequence of): <b>b. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>c. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>d. INSULIN DEPENDENT DIABETES MELLITUS</b>				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 				29c. License number <b>D0034231</b>		29d. Date signed (Month, Day, Year) <b>Jan 2, 2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robin L. Bissell, M.D., 124 Miller St., Grantsville, MD 21536</b>				31. Date filed (Month, Day, Year) <b>JAN 05 2004</b>				
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



1- For  
State  
Registrar

2004 01598

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH LEE MILLER</b>				2. Date of Death Month <b>JANUARY</b> Day <b>4</b> Year <b>2004</b>				3. Time of Death <b>10:02 A<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>813 MT. ROYAL AVENUE</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>				4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>217-28-7642</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR. 9, 1932</b>		9. Birthplace (State or Foreign Country) <b>WEST VIRGINIA</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>ALLEGANY</b>		10c. City, Town or Location <b>CUMBERLAND</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <b>813 MT. ROYAL AVENUE</b>				10f. Zip Code <b>21502</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MILITARY/DISASTER SERV. COORD.</b>				16b. Kind of Business/Industry <b>AMERICAN RED CROSS</b>		
17. Father's Name (First, Middle, Last) <b>BENJAMIN FRANKLIN TUCKER</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>PEARL PAYNE</b>					
19a. Informant's Name/Relationship (Type, Print) <b>MARK MILLER / SON</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>803 FLETCHER DRIVE, CUMBERLAND, MD 21502</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CUMBERLAND CREMATORY</b>			Date <b>01/05/2004</b>		20c. Location - City or Town, State <b>Cumberland</b> <del>CUMBERLAND, MD</del>		
21. Signature of Funeral Service Licensee <i>George A. Upchurch</i>			22. Name and Address of Facility <b>UPCHURCH FUNERAL HOME, P.A.</b> <b>202 GREENE STREET, CUMBERLAND, MD 21502</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lymphoma, Stage IV</b> Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Paul R. Jan 4, 04</b>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. <b>Pulmonary Embolism</b> <b>Respiratory Failure</b>								23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>R. Espina, MD</i>			29c. License number <b>TD 03459</b>		29d. Date signed (Month, Day, Year) <b>1/5/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. ESPINA 902 Seton Drive, Cumberland Md</b>										
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>			32. Registrar's Signature <i>B. Sparks</i>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01599

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Andrew Francis Mroz</b>			2. Date of Death Month Day Year <b>January 7, 2004</b>		3. Time of Death <b>2:16 P M</b>		
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>			4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>217-34-8291</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6-28-1938</b>	
	9. Birthplace (State or Foreign Country) <b>Baltimore, MD</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent			10a. State <b>MD</b>		10b. County <b>Charles</b>		
	10c. City, Town or Location <b>Waldorf</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>5322 Doris Drive</b>			10f. Zip Code <b>20601</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Vice Pres. Labor Relations</b>		16b. Kind of Business/Industry <b>Dairy</b>			
	17. Father's Name (First, Middle, Last) <b>Andrew Mroz</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ann Marie Barry</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia A. Mroz - wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5322 Doris Drive, Waldorf, MD 20601</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Huntt Crematory</b>		20c. Location - City or Town, State <b>1-8-2004 Waldorf, MD</b>			
	21. Signature of Funeral Service Licensee <b>Mark S. Behaun</b>		22. Name and Address of Facility <b>Huntt Funeral Home</b>		22. Name and Address of Facility <b>P.O. Box 156, Waldorf, MD 20604</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>ischemic bowel</b> Due to (or as a consequence of): b. <b>peritonitis</b> Due to (or as a consequence of): c. <b>pneumonia</b> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>710d</b> <b>710d</b> <b>710d</b>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>acute renal failure</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Robert Peterson MD</b>		29c. License number <b>024804</b>		29d. Date signed (Month, Day, Year) <b>1-07-2004</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Peterson MD ATMC Annapolis Md 21401</b>								
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature <b>Kevin D. Spiller</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01600

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alma Ruth Mahoney</b>			2. Date of Death Month Day Year <b>January 5, 2004</b>		3. Time of Death <b>6:29p</b> M	
	4a. Facility Name (If not institution, give street and number) <b>Bowie Health Care Center</b>			4b. City, Town, or Location of Death <b>Bowie</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>049-05-2736</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 9, 1918</b>
	9. Birthplace (State or Foreign Country) <b>CT</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Upper Marlboro</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number <b>17128 Fairway View Lane</b>			10f. Zip Code <b>20772</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed <b>XX</b>		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>XX</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookkeeper</b>		16b. Kind of Business/Industry <b>Chesapeake Construction Company</b>		
	17. Father's Name (First, Middle, Last) <b>Emil Woike</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Banks</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Sheila Hutson (Daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17128 Fairway Fiew Lane Upper Marlboro, MD 20772</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		20c. Date <b>Jan. 7, 2004</b>		20d. Location - City or Town, State <b>Clinton, Maryland</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinotn, MD20735</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. <b>Cardiac Arrythmia</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of):						
	c. Due to (or as a consequence of):						
	d. Due to (or as a consequence of):						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>Lynn A. Thomas, MD</b>		29c. License number <b>DD057400</b>		29d. Date signed (Month, Day, Year) <b>1/6/04</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LYNN A. THOMAS, MD 1221 MERCANTILE LANE, LARGO, MD</b>							
31. Date filed (Month, Day, Year) <b>JAN 08 2004</b>		32. Registrar's Signature <b>Anna B. Spotts</b> <b>20774</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01601

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Peggy A. Maass

2. Date of Death

January 1, 2004

3. Time of Death

5:15P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5106 Brookview Drive

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

474-54-4596

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45 Yrs.

8. Date of Birth (Month, Day, Year)

Sept. 7, 1958

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5106 Brookview Drive

10f. Zip Code

20816

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Systems Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Phillip Maass

18. Mother's Name (First, Middle, Maiden Surname)

Lois Jean Amundson

19a. Informant's Name/Relationship (Type, Print)

David W. Baker/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5106 Brookview Drive; Bethesda, MD 20816

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

01/06/2004

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Simple Tribute Funeral and Cremation Center  
1040 Rockville Pike; Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Hodgkin's Lymphoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

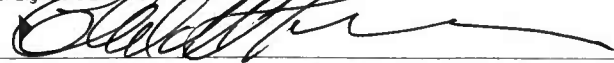
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier



29c. License number

D00041218

29d. Date signed (Month, Day, Year)

01/05/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Harrison, MD 6001 Muncaster Mill Road; Rockville, MD 20855

State Registrar

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND#19 per TH 1/7/04, BW, MCO  
AMEND#20 per MD 1/7/04, BW, MCO

State of Maryland / Department of Health and Mental Hygiene

2004 01602

1- State Registrar AMEND#11 per TH 1/6/04, BW, MCO  
AMEND#18 per TH 1/6/04, BW, MCO  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary M. Macgregor</b>		2. Date of Death Month <b>January</b> Day <b>4</b> Year <b>2004</b>		3. Time of Death <b>3:35 a M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Potomac Valley Nursing &amp; Wellness Ctr.</b>		4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>577-48-2119</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Oct. 30, 1914</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent					
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Kensington</b>	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number <b>4717 Saul Road</b>		10f. Zip Code <b>20895</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>		16b. Kind of Business/Industry <b>Health Care</b>	
	17. Father's Name (First, Middle, Last) <b>Phillip Moore</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Cuff</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Marguerite M. Fox/ Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4732 Crossgate Road, Chester, VA 23831</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Louis Cemetery</b>		20c. Location - City or Town, State <b>Clarksville, Maryland</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Advanced Dementia</b> Due to (or as a consequence of): b. <b>Hypertension</b> Due to (or as a consequence of): c. <b>Cerebrovascular Accident</b> Due to (or as a consequence of): d. <b>Flu Syndrome</b>					Approximate Interval Between Onset and Death
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown
	23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)						
28b. Time of Injury M						
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
28d. Describe how injury occurred						
28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 			29c. License number <b>D59284</b>		29d. Date signed (Month, Day, Year) <b>January 5, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>S. Shamim M.D. 1299 Lambertson Drive, Silver Spring, MD 20902</b>						
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01603

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Mary Martha Maher</b>		2. Date of Death Month Day Year <b>January 1, 2004</b>		3. Time of Death <b>1:30 A<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>20600 Dubois Court</b>		4b. City, Town, or Location of Death <b>Montgomery Village</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>214-42-0033</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>105</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>April 14, 1898</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Montgomery Village</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>20600 Dubois Court</b>		10f. Zip Code <b>20886</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>	
17. Father's Name (First, Middle, Last) <b>Michael Manley</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Logsdon</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mary Catherine Monte Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7109 Ridgewood Avenue Chevy Chase, Maryland 20815</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>Jan. 3, 2004 Alexandria, Virginia</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>End-Stage Cardiac Disease</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>years</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D 09834</b>		29d. Date signed (Month, Day, Year) <b>January 2, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Barry N. Rosenbaum, M.D. 3720 Farragut Avenue Kensington, MD 20895</b>					
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 50528.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01604

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mercedes Barry Manders

2. Date of Death  
Month Day Year  
January 5, 2004

3. Time of Death  
6:45PM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-30-5629

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 30, 1926

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5550 Tuckerman Lane

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

David E. Barry

18. Mother's Name (First, Middle, Maiden Surname)

Isabel Purcell

19a. Informant's Name/Relationship (Type, Print)

William E. Manders/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9141 Brookville Road, Silver Spring, Maryland 20910

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Jan. 9, 2004

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

*David E. Barry* M00803

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Rockville, Inc. 300 West Montgomery Avenue  
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Pneumonia*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Cristin Parker Howe MD*

29c. License number

D0059871

29d. Date signed (Month, Day, Year)

January 5, 2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Cristin Parker Howe MD 9901 Medical Center Drive Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01605

Physician / Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Catherine C. Masters</b>		2. Date of Death Month Day Year <b>January 1, 2004</b>		3. Time of Death <b>11:20 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>		4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>	
5. Social Security Number <b>087-05-5048</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Aug. 10, 1919</b>	9. Birthplace (State or Foreign Country) <b>New York</b>	
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3112 Gracefield Road</b>		10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Recreation Director</b>		16b. Kind of Business/Industry <b>Federal Government</b>	
17. Father's Name (First, Middle, Last) <b>James Clyne</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Frances Hoban</b>			
19a. Informant's Name/Relationship (Type, Print) <b>William E. Masters/ Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>771 Chautauqua Blvd., Pacific Palisades, CA 90272</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Pneumonia</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arrhythmia, Deep Venous Thrombosis</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D24174</b>		29d. Date signed (Month, Day, Year) <b>Jan. 21 04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Padmaji Udapi M. D. 7350 Van Dusen, #380, Laurel, MD 20707</b>					
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01606

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Mayer

2. Date of Death

Month Day Year  
January 2, 2004

3. Time of Death

10:30 P.M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

100-16-0382

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
November 18, 1912

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Montgomery10c. City, Town or Location  
Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8100 Connecticut Avenue #1222

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Language Instructor

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Otto Koch

18. Mother's Name (First, Middle, Maiden Surname)

Ida Kahn

19a. Informant's Name/Relationship (Type, Print)

Steven Mayer/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1216 Powderhorn Terrace, Minneapolis, MN 55407

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Geo. Wash. University  
Medical Center

Date

January 6  
2004

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Columbia Mortuary Services, Inc.  
P.O. Box 58007 Washington, D.C. 2003723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Stroke

Approximate  
Interval Between  
Onset and Death  
2 DaysSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D059303

29d. Date signed (Month, Day, Year)

January 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.H. Dunn, M.D. 8600 Old Georgetown Rd. Bethesda, MD 20814

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01607

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Dorothy May McAdams</b>		2. Date of Death Month Day Year <b>January 1, 2004</b>		3. Time of Death <b>5:42 P<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>		4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>219-12-2976</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>April 28, 1923</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>321 University Blvd., West #112</b>		10f. Zip Code <b>20901</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Worthy Sanders</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Cox</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Francis J. McAdams, Jr. Husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>321 University Blvd., West #112 Silver Spring, MD 20901</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Location - City or Town, State <b>Jan. 5, 2004 Silver Spring, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 1500 University Blvd., W., Silver Spring, MD 20901</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Cardiac Arrest</b> Due to (or as a consequence of): b. <b>Sepsis</b> Due to (or as a consequence of): c. <b>Pneumonia</b> Due to (or as a consequence of): d.					
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cervical Cancer</b> <b>Heart Failure</b>					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D0059151</b>		29d. Date signed (Month, Day, Year) <b>1/2/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Catherine Godfrey, M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910</b>					
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01608

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Joseph McCarthy

2. Date of Death  
Month Day Year

January 4, 2004

3. Time of Death

5:15 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

136-32-3102

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Jan. 8, 1914

9. Birthplace (State or Foreign  
Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6011 Kingsford Court

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ NoIf Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Robert McCarthy

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Murphy

19a. Informant's Name/Relationship (Type, Print)

Michael E. McCarthy/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6521 Wrenview Court, Dayton, Ohio 45424

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National

Cemetery

Date

January 21,

2004

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

M01346

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Ventricular Fibrillation

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
MinutesSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Atherosclerotic Coronary Artery Disease

Due to (or as a consequence of):

Years

c. Dyslipidemia

Due to (or as a consequence of):

Years

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thrombocytopenia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

40576

29d. Date signed (Month, Day, Year)

January 4, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramin Roskovi, M.D. 3301 New Mexico Ave. N.W. Suite 202, Washington, D.C. 20016

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
5026.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

McCarthy, Robert J., DR. 1/4/04 5:15AM

30+1  
10

## Certificate of Death

Reg. No.

2004 01609

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ANGELA MEMMO

2. Date of Death

January 3, 2004

3. Time of Death

0535 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

217-70-4441

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 31, 1953

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5306 Flanders Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Special Education Bus Attendant

16b. Kind of Business/Industry

Montgomery County  
Public Schools

17. Father's Name (First, Middle, Last)

Samuel Peter Memmo

18. Mother's Name (First, Middle, Maiden Surname)

Yolanda F. Goffredo

19a. Informant's Name/Relationship (Type, Print)

Yolanda F. Memmo/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5306 Flanders Avenue, Kensington, MD 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)  
Gate of Heaven  
Cemetery

Date

January 6  
2004

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

James S. Dooly

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.  
500 University Blvd. W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
Years

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERCHOLESTEROLEMIA, HYPOTHYROIDISM

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James S. Dooly

29c. License number

A15234

29d. Date signed (Month, Day, Year)

January 3, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL I. WYNNE JR 11145 ROCKVILLE PIKE, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

James S. Dooly

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

Released to the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in, the funeral director, page 2 should be detached for use as the burial-transit  
certificate. File in the funeral home file. 113-104535A

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **2004 01610**  
**Certificate of Death**

1- For  
State  
Registrar

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: if item 27 is marked other than "natural", or items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Leonarda R. Mercado</b>				2. Date of Death Month Day Year <b>January 3, 2004</b>		3. Time of Death <b>2:20 a.m.</b>	
4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>051-30-1397</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>103</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 6, 1900</b>	9. Birthplace (State or Foreign Country) <b>Puerto Rico</b>
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3 Arlive Court</b>				10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>Puerto Rican</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Jose Antonio Rodriguez</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Florentina Irizarry</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Iris Mercado Fenton/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Arlive Court, Rockville, MD 20854</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>January 7 2004</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>			

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Pulmonary Edema</b> Due to (or as a consequence of): b. <b>Septicemia</b> Due to (or as a consequence of): c. <b>Acute Pyelonephritis</b> Due to (or as a consequence of): d. <b></b>				Approximate Interval Between Onset and Death	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>Hypertension</b>				23a. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D46945</b>		29d. Date signed (Month, Day, Year) <b>January 3, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>T. A. DeTutu M.D. P.O. Box 7000, Largo, MD 20792</b>					
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature 			

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01611

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Marianne Messenger</b>		2. Date of Death Month Day Year <b>January 4 2004</b>		3. Time of Death <b>12:00 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>		4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>209-38-7958</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>June 28, 1946</b>		9. Birthplace (State or Foreign Country) <b>PA</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Montgomery Village</b>	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number <b>19537 Gallatin Court</b>		10f. Zip Code <b>20886</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Art Teacher</b>		16b. Kind of Business/Industry <b>Elementary School</b>	
17. Father's Name (First, Middle, Last) <b>Partick John Walsh</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Joan Dragon</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Matthew P. Messenger/ Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19537 Gallatin Court, Montgomery Village, MD 20886</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>January 6 2004 Alexandria, Virginia</b>	
21. Signature of Funeral Service Licensee <b>Tracey A. Stover</b>		22. Name and Address of Facility <b>DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic Breast Cancer</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>2 yrs</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Frederick G. Barr, M.D.</b>		29c. License number <b>022775</b>		29d. Date signed (Month, Day, Year) <b>1-5-04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frederick G. Barr, M.D., 2101 Medical Park Drive, #201, Silver Spring, MD 20902</b>					
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>		32. Registrar's Signature <b>Barbara B. Sparks</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

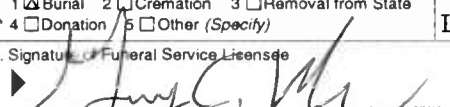
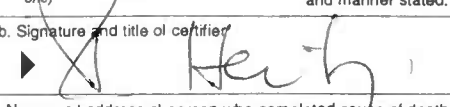
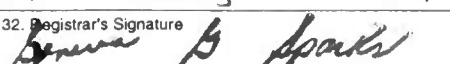
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01612

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Pauline N. Miller</b>				2. Date of Death Month <b>January</b> Day <b>2</b> Year <b>2004</b>		3. Time of Death <b>8:45 P<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>213-12-7726</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 15, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>415 Russell Avenue #213</b>		10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Logistician</b>		16b. Kind of Business/Industry <b>Department of the Army</b>			
	17. Father's Name (First, Middle, Last) <b>Clarence Needy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Irene Norris</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Myron Miller / Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>415 Russell Avenue #213 Gaithersburg, MD 20877</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lind Memorial Methodist</b>		Date <b>Jan. 8, 2004</b>		20c. Location - City or Town, State <b>Lewistown, PA</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>10 E. Deer Park Dr. Gaithersburg, MD 20877</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Septic shock</b> Approximate Interval Between Onset and Death <b>24 hrs</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Intraabdominal sepsis</b> <b>24 hrs</b>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Massive upper gastro intestinal bleed</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>MD</b>		29c. License number <b>00054062</b>		29d. Date signed (Month, Day, Year) <b>01/02/2004</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Isabelle Herbig MD - Shady Grove Hospital 9901 Medical Center Drive Rockville - Maryland</b>								
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01613

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last) Rachel Long Misy				2. Date of Death January 3, 2004				3. Time of Death 12:05 AM			
4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery			
5. Social Security Number 444-24-9436		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 4, 1924		9. Birthplace (State or Foreign Country) Oklahoma			
Usual Residence of Decedent											
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 11410 Strand Drive, Apt. 409				10f. Zip Code 20852				10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian				16b. Kind of Business/Industry District of Columbia Public Library			
17. Father's Name (First, Middle, Last) Clarence Long						18. Mother's Name (First, Middle, Maiden Surname) Odie McLaughlin					
19a. Informant's Name/Relationship (Type, Print) Johanna Misy Boyer/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 Twin Holly Lane, Silver Spring, Maryland 20910-4665					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.				20c. Location - City or Town, State Bethesda, Maryland			
21. Signature of Funeral Service Licensee M01356				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Subarachnoid Hemorrhage Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier John W. Barrett, M.D.				29c. License number D021781		29d. Date signed (Month, Day, Year) 1/6/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Barrett, M.D. 4927 Auburn Avenue, #200 Bethesda, Maryland 20814											
31. Date filed (Month, Day, Year) JAN 09 2004				32. Registrar's Signature B. Sparks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01614

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Janet G. Montgomery

2. Date of Death

January 6, 2004

3. Time of Death

6:15 a.m.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-62-4315

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 9, 1948

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2826 Hardy Avenue

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Worth Lane

18. Mother's Name (First, Middle, Maiden Surname)

Rena Johnson

19a. Informant's Name/Relationship (Type, Print)

Michelle J. Lane/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2826 Hardy Avenue, Silver Spring, MD 20902

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

January 12  
2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.  
500 University Blvd. W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

SEPSIS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown

3. Ectopic pregnancy

5. Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an  
autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D0057124

29d. Date signed (Month, Day, Year)

11/7/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao M.D 13219 Executive Park Terrace, Germantown, MD 20879

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

10

1-6-04 0615 AM  
MONTGOMERY, JANET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01615

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frank Ton Moy</b>				2. Date of Death Month Day Year <b>Jan. 2, 2004</b>				3. Time of Death <b>1:41p M</b>			
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>339-22-4219</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>1/12/1922</b>		9. Birthplace (State or Foreign Country) <b>China</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>Md</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits <b>1 Yes 2 No</b>			
	10e. Street and Number <b>802 Wayne Avenue</b>				10f. Zip Code <b>20910</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>				14. Race - American Indian, Black, White, etc. <b>Specify: Asian</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10 College (1-4 or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self employed</b>				16b. Kind of Business/Industry <b>Laundry/Dry Cleaners</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Willie Moy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Kee Ho Chin</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Louise Moy Shu/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3412 Glenmoor Dr. Chevy Chase, Md 20815</b>							
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crem.</b>		Date <b>1/04/04</b>		20c. Location - City or Town, State <b>Beltsville, Md</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md 20910</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>a. <b>Pneumonia</b> Due to (or as a consequence of):</p> <p>b. <b>Sepsis</b> Due to (or as a consequence of):</p> <p>c. <b>Gastric Cancer</b> Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 50%; border-left: 1px solid black; padding-left: 10px;"> </div> </div>											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>				23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown</b>				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b>		26. Place of Death (Check only one) Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
	27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>											
State Registrar	29b. Signature and title of certifier 				29c. License number <b>D00058965</b>		29d. Date signed (Month, Day, Year) <b>1/02/04</b>					
	30. Name and address of person who completed cause of death (Item 22a) (Type, Print) <b>Khawaja Saima M.D. 1500 Forest Glen Rd Silver Spring, Md</b>											
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01616

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

VIVIAN NICK

2. Date of Death

Month Day Year JAN 8 2004

3. Time of Death

4:30 M

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

215-26-3761

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

8. Date of Birth (Month, Day, Year)

Oct. 7 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Shady Side

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1421 Shady Rest Road

10f. Zip Code

20764

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Thomas Motor Tour

17. Father's Name (First, Middle, Last)

Stephen G. Rice

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Wallace

19a. Informant's Name/Relationship (Type, Print)

Caremlia A. Hicks (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1011 Red Maple View Terrace Churchton, Maryland 20733

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Matthews UM Church Cemetery

Date

1/13/04

20c. Location - City or Town, State

Shady Side, Md.

21. Signature of Funeral Service Licensee

Larry H. Reese M00483

22. Name and Address of Facility

Wm. Reese & Sons Mortuary, P.A.  
821 West St. Annapolis, Md. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL HEMORRHAGE

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

12 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harvey J. Steinfeld MD

29c. License number

D05158

29d. Date signed (Month, Day, Year)

01/08/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARVEY J. STEINFELD MD. 6131 SHADY SIDE RD SHADY SIDE MD 20764

31. Date filed (Month, Day, Year)

JAN 12 2004

32. Registrar's Signature

Ann B. Apple

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01617

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Mary Nieberding

2. Date of Death

January 3, 2004

3. Time of Death

12:08 a.m.

4a. Facility Name (If not institution, give street and number)

Cranberry Cottage

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

214-22-5135

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 1, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

394 Washington Ave.

10f. Zip Code

21060

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Slawski

18. Mother's Name (First, Middle, Maiden Surname)

Petronilla Skozyiowicz

19a. Informant's Name/Relationship (Type, Print)

Pauline Shaney (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7869 Crilley Rd. #430 Glen Burnie, MD. 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Cntr.

Date

Jan 6, 2004

20c. Location - City or Town, State

Chester, Maryland

21. Signature of Funeral Service Licensee

M00982

22. Name and Address of Facility

Adams Funeral & Memorial Care  
814 Bestgate Rd. Annapolis, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Breast Cancer

Approximate Interval Between Onset and Death

9 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
Dementia

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

3 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted Living

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D20094

29d. Date signed (Month, Day, Year)

1/04/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elliott Garbutt, 1411 Madison Park Drive, Glen Burnie, MD, 21061

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01618

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANDREW HOWARD NORFORD

2. Date of Death

Month Day Year  
JANUARY 03 2004

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

BROOKLE GROVE REHABILITATION CENTER

4b. City, Town, or Location of Death

SANDY SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579-07-4331

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 7, 1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11573 Rest Drive

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1943-4513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Switchman

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Howard B. Norford

18. Mother's Name (First, Middle, Maiden Surname)

Roberta King

19a. Informant's Name/Relationship (Type, Print)

Craig D. Norford/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11573 Rest Drive, La Plata, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

January 7  
2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.  
500 University Blvd. W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE RENAL FAILURE

Due to (or as a consequence of):

b. DEHYDRATION

Due to (or as a consequence of):

c. DYSPHAGIA

Due to (or as a consequence of):

d. CEREBROVASCULAR DISEASE

Approximate  
Interval Between  
Onset and Death

DAYS

DAYS

WEEKS

YEARS

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_\_  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

STAFF PHYSICIAN

29c. License number

D42046

29d. Date signed (Month, Day, Year)

JANUARY 03, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRACE BROCKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING MARYLAND 20860

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01619

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Susan J. Noon</b>		2. Date of Death Month Day Year <b>January 4, 2004</b>		3. Time of Death <b>2:12 P<sup>M</sup></b>
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>		4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>207-24-9144</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 17, 1928</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Prince Georges</b>	10c. City, Town or Location <b>Hyattsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>7308 16th P1</b>		10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Artist</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) <b>College (1-4 or 5+)</b>		16b. Kind of Business/Industry <b>Art</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Lawrence Kratz</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Haughton</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Leslie Pickett/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>652 Chapelview Dr, Odenton, MD 21113</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Riverside Cemetery</b>		20c. Location - City or Town, State <b>Jan 9, 2004 W. Norton Twp, PA</b>
	21. Signature of Funeral Service Licensee <b>Alamy Wonnell</b>		22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home</b> <b>11800 New Hampshire Ave, Silver Spring, MD 20904</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Intra cerebral Bleed</b> Due to (or as a consequence of): <b>Coagulopathy</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Intra cerebral Bleed</b> Due to (or as a consequence of): <b>Coagulopathy</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>2 Days</b> <b>unknown</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)	
23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <b>M. Karim MD</b>		29c. License number <b>518895</b>	
29d. Date signed (Month, Day, Year) <b>January 5, 2004</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MD 20912</b>			
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>		32. Registrar's Signature <b>B. Sparks</b>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01620

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Johnson Nelson

2. Date of Death

January 2, 2004

3. Time of Death

5:00 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7601 Seans Terrace

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

138-44-8597

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 31, 1952

9. Birthplace (State or Foreign Country)

Waynesboro, GA.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7601 Seans Terrace

10f. Zip Code

20706

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse / Administrator

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Johnny Luke

18. Mother's Name (First, Middle, Maiden Surname)

Eliza Johnson

19a. Informant's Name/Relationship (Type, Print)

Eddie M. Nelson (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7601 Seans Terrace, Lanham, Md. 20706

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory


Date

January 4, 2004

20c. Location - City or Town, State

Beltsville, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Rapp Funeral AND Cremation Services  
933 Gist Ave., Silver Spring, Md. 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Endometrial Cancer  
Due to (or as a consequence of):  
b. Bowel Obstruction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Renal Failure  
Due to (or as a consequence of):  
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

M 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

039145

29d. Date signed (Month, Day, Year)

1-2-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles R. Boice, M.D.; 10301 Georgia Ave, # 205, Silver Spring, Md. 20902

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01621

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Margaret Oak

2. Date of Death  
Month Day Year

January 13, 2004

3. Time of Death

12:20 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Mairner of Greater Laurel

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

169-14-5269

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

Jan 16, 1921

9. Birthplace (State or Foreign  
Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7700 Cherry Lane

10f. Zip Code

20707

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

William Wilber Oak

18. Mother's Name (First, Middle, Maiden Surname)

Mini Porter

19a. Informant's Name/Relationship (Type, Print)

David Kriebs/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13121 Idlewild Drive, Bowie, MD 20715

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Huntt Crematory

Date

1/14/2004

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

▶ *Kull*

22. Name and Address of Facility

Robert E. Evans Funeral Home,  
16000 Annapolis Road, Bowie, Maryland 2071523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 month

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Undifferentiated Carcinoma

Due to (or as a consequence of):

1 month

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ *Bennett* MD

29c. License number

D54488

29d. Date signed (Month, Day, Year)

1-13-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennett So, MD, 8317 Cherry Lane, Laurel, MD 20707

31. Date filed (Month, Day, Year)

JAN 14 2004

32. Registrar's Signature

▶ *[Signature]*State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01622

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley I. O'Bryant

2. Date of Death

January 4, 2004

3. Time of Death

3:14 a. M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7877 Bellehaven Ave.

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

5. Social Security Number

281-10-4127

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

8. Date of Birth

November 24, 1908

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7877 Bellehaven Ave.

10f. Zip Code

21122

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Van Hoose

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Boling

19a. Informant's Name/Relationship (Type, Print)

Esta Ginneman (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7877 Bellehaven Ave. Pasadena, MD. 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairview Cemetery

Date

Jan. 9, 2004

20c. Location - City or Town, State

Champaign, Ohio

21. Signature of Funeral Service Licensee

M00982

22. Name and Address of Facility

Adams Funeral &amp; Memorial Care

814 Bestgate Road Annapolis, Maryland 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure  
Due to (or as a consequence of):Approximate Interval Between Onset and Death  
months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D50725

29d. Date signed (Month, Day, Year)

1-5-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jenn. fer Riedinger 8601 Veterans Hwy M. Uersville, MD

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

21108

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01623

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE JOSEPH OTT

2. Date of Death

January 1, 2004

3. Time of Death

11:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

15851 Smith Road

4b. City, Town, or Location of Death

Thurmont

4c. County of Death

Frederick

5. Social Security Number

219-12-2292

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 19, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15851 Smith Road

10f. Zip Code

21788

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

John Baptist Ott, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ida Amanda Miller

19a. Informant's Name/Relationship (Type, Print)

Lee Ott (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 Depaul Street, PO Box 803, Emmitsburg, MD 21727

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Blue Ridge Cemetery

Date

1/5/04

20c. Location - City or Town, State

Thurmont, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY &amp; SON, FUNERAL HOMES, P.A.

615 EAST MAIN ST., THURMONT, MD 21788

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure

Due to (or as a consequence of):

Advanced Chronic Obstructive Lung Disease 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

A18705

29d. Date signed (Month, Day, Year)

1/7/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Carroll MD 310 S. Seton Ave Emmitsburg Md, 21727

31. Date filed (Month, Day, Year)

JAN - 8 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01624

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mary Jane Plummer

2. Date of Death  
Month Day Year  
January 7, 20043. Time of Death  
6:55 AM

4a. Facility Name (If not institution, give street and number)

255 Lums Road

4b. City, Town, or Location of Death

North East

4c. County of Death

Cecil

5. Social Security Number

215-32-4673

6. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
Yrs. 68

8. Date of Birth (Month, Day, Year)

December 26, 1935 Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

255 Lums Road

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Albert William Plummer

18. Mother's Name (First, Middle, Maiden Surname)

Mary Marshall Barbre

19a. Informant's Name/Relationship (Type, Print)

Benjamin R. McRoberts/Companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

255 Lums Road, North East, Maryland 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Bel Air Memorial  
GardensDate  
January 12,  
2004

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Crouch Funeral Home

127 South Main Street, North East, Maryland 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC CARCINOMA BLADDER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

5

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

001858MD

29d. Date signed (Month, Day, Year)

1/9/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Robert Gray 204 South Street ELKTON, MD 21921

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or item 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01625

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN ARTHUR PRITCHARD				2. Date of Death Month Day Year January 4 2004		3. Time of Death 1450 M	
	4a. Facility Name (If not institution, give street and number) 3819 Early Glow Lane				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 533-36-2348		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 19, 1939	
	9. Birthplace (State or Foreign Country) TENNESSEE		10a. State MARYLAND		10b. County PRINCE GEORGE'S		10c. City, Town or Location BOWIE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3819 EARLY GLOW LANE		10f. Zip Code 20716		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1964-68		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHYSICAL SCIENTIST		16b. Kind of Business/Industry U. S. FEDERAL GOVERNMENT			
	17. Father's Name (First, Middle, Last) JOHN RALPH PRITCHARD				18. Mother's Name (First, Middle, Maiden Surname) MARY LOUISE DURKEE			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ROBERT T. PRITCHARD/BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3835 9TH ST., NORTH #202E, ARLINGTON, VA 22203			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERANS		20c. Location - City or Town, State 1/12/2004 CROWNSVILLE, MARYLAND		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME, 16000 ANNAPOLIS ROAD, BOWIE, MARYLAND 20715			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Hypertensive Heart Disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the causa of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier [Signature]		29c. License number 16055827		29d. Date signed (Month, Day, Year) January 5, 2004			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador S. Castro, 3001 Hospital Drive, Chevy Chase, Maryland							
State Registrar	31. Date filed (Month, Day, Year) JAN 07 2004		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01626

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Laura Belia Penna				2. Date of Death Month Day Year January 2 2004				3. Time of Death 9:00A M	
	4a. Facility Name (If not institution, give street and number) 19706 Frog Eye Road				4b. City, Town, or Location of Death Knoxville				4c. County of Death Washington	
Funeral Director	5. Social Security Number 460-48-8962		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Oct 3, 1935		9. Birthplace (State or Foreign Country) El Paso, Texas	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Washington		10c. City, Town or Location Knoxville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 19706 Frog Eye Road				10f. Zip Code 21758		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse			16b. Kind of Business/Industry Vienna Pediatrics		
	17. Father's Name (First, Middle, Last) Benjamin Lopez					18. Mother's Name (First, Middle, Maiden Surname) Elvira Chavira				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Richard P. Penna, Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19706 Frog Eye Road, Knoxville, MD 21758					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date 1/8/04		20c. Location - City or Town, State Hagerstown, MD			
	21. Signature of Funeral Service Licensee Barbara A. Williams, Owner				22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Upper Gastrointestinal Bleeding Due to (or as a consequence of): b. Advanced Colon Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Days 7 years									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Dr. Kannan HudHud										
29c. License number D41866										
29d. Date signed (Month, Day, Year) January 05, 2004										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kannan HudHud, 801 Toll House Road, Frederick, MD 21701										
31. Date filed (Month, Day, Year) JAN - 5 2004										
32. Registrar's Signature Benita Sparks										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01627

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Howard Cassius Paine

2. Date of Death

January 3, 2004

3. Time of Death

11:45AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Buckingham's Choice

4b. City, Town, or Location of Death

Adamstown

4c. County of Death

Frederick

5. Social Security Number

559-32-7241

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 8, 1911

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Adamstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3200 Baker Circle, #A-101

10f. Zip Code

21710

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No World

If Yes, Give Year or Dates: War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Federal

Government

17. Father's Name (First, Middle, Last)

Charlie Bruce Paine

18. Mother's Name (First, Middle, Maiden Surname)

Frances Vasey

19a. Informant's Name/Relationship (Type, Print)

Joan P. Porter/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1213 Jefferson Pike, Knoxville, Maryland 21758

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parklawn Memorial Park

Date

January 9,

2004

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M00689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

10 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBRO VASCULAR ACCIDENT

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-31912

29d. Date signed (Month, Day, Year)

1/05/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIO MENDIA, MD, 1564 OPOLOMOWN PIKE WREDS RICH MD 21702

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



AMENDED BY COURT ORDER Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

amend item 11 per court order 8967 9-16-15 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01628

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Carlos Vicente Palacios Castro</b>		2. Date of Death Month Day Year <b>January 3, 2004</b>		3. Time of Death <b>10:40 A M</b>	
4a. Facility Name (If not institution, give street and number) <b>Casey House Montgomery Hospice</b>		4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>610-60-3233</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>39</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Oct. 11, 1964</b>		9. Birthplace (State or Foreign Country) <b>El Salvador</b>			
Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>	
10c. City, Town or Location <b>Gaithersburg</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>82 West Deer Park Road, #204</b>		10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>El Salvador</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Salvadoran</b>	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>	
16b. Kind of Business/Industry <b>Construction</b>		17. Father's Name (First, Middle, Last) <b>Vicente Palacios</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Maria Castro</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Alba Antonia Cortez de Palacios</b> <b>Alba C. Palacios/wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>82 West Deer Park Road, #204, Gaithersburg, Maryland 20877</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>All Souls Cemetery</b>		20c. Location - City or Town, State <b>Germantown, Maryland</b>	
21. Signature of Funeral Service Licensee <b>John P. Chapler</b> M00092		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home</b> <b>Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue</b> <b>Bethesda, Maryland 20814</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Gastric Cancer</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Due to (or as a consequence of):</b> <b>Due to (or as a consequence of):</b> <b>Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>18 Months</b>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b> 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Joseph Kaplan</b>		29c. License number <b>D35635</b>	
29d. Date signed (Month, Day, Year) <b>January 3, 2004</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Kaplan, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855</b>			
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature <b>Benita B. Sparks</b>			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01630

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PETER K. PETERSON

2. Date of Death

JAN, 1, 2004

3. Time of Death

9:40PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HOWARD C. GEN HOST

4b. City, Town, or Location of Death

Columbia

4c. County of Death

HOWARD

5. Social Security Number

291-74-6064

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

4-16-1929

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7323 Kerry Hill Ct.

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Asian-Indian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Blue Cross/Blue Shield

17. Father's Name (First, Middle, Last)

Puthukunanthan

18. Mother's Name (First, Middle, Maiden Surname)

Pariduranam

19a. Informant's Name/Relationship (Type, Print)

Sherwine P. John - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

925 High Stepper Trail, Skyesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Geo. Wash. Cem.

Date

1-4-04

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi F. H.

11800 New Hampshire Ave., Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Acute myocardial infarction  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 hr

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. coronary arterial disease  
Due to (or as a consequence of):

several yrs

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin dependent diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ POA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

P. K. Peterson

29c. License number

D37777

29d. Date signed (Month, Day, Year)

JAN 3rd, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER CHEN 2 KNOLE NORTH DR. COLUMBIA MD 21045

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

P. A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01631

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BRUCE G. PHILIPSON

2. Date of Death

Month Day Year  
JANUARY 4, 2004

3. Time of Death

9:10 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

577-32-7802

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT. 24, 1927

9. Birthplace (State or Foreign Country)

WASHINGTON DC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7004 MARBURY ROAD

10f. Zip Code

20817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CERTIFIED PUBLIC ACCOUNTANT

16b. Kind of Business/Industry

ACCOUNTING

17. Father's Name (First, Middle, Last)

ROBERT

PHILIPSON

18. Mother's Name (First, Middle, Maiden Surname)

LILLIAN

GLUECK

19a. Informant's Name/Relationship (Type, Print)

SELMA B. PHILIPSON/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7004 MARBURY RD., BETHESDA, MD 20817

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDEN OF REMEMBRANCE

Date

01/07/2004

20c. Location - City or Town, State

CLARKSBURG, MARYLAND

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.  
1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non-Hodgkin's Lymphoma  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy performed?  
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gregory A. Compton MD

29c. License number

D24942

29d. Date signed (Month, Day, Year)

JAN 5 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY A. COMPTON, MD 6121 Montrose Rd Rockville, MD

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

Benjamin S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

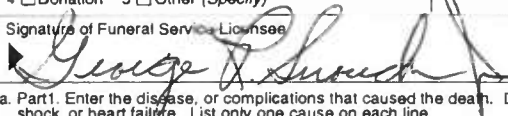


To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 Amend Items 10c,e,f, per FH, 6832.07/18/04dhp  
 Certificate of Death  
 Reg. No. 2004 01632

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOROTHY E. PIATT</b>		2. Date of Death Month Day Year <b>Jan. 7, 2004</b>		3. Time of Death <b>4:16P<sup>M</sup></b>
	4a. Facility Name (If not institution, give street and number) <b>Casey House</b>		4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>167-22-7331</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Nov. 24, 1927</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Poolesville Silver Spring</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number <b>8505 Springvale Rd. #245</b> <del>19544 Fisher Ave</del>		10f. Zip Code <b>20837 20910</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner-Operator</b>		16b. Kind of Business/Industry <b>Dairy Queen</b>		
	17. Father's Name (First, Middle, Last) <b>James Emory</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Saunders</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Nancy Swank - Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19544 Fisher Ave Poolesville, MD 20837</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Irwin Union Cem</b>		20c. Location - City or Town, State <b>1/12/2004 Huntington, PA</b>
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Snowden Funeral Home, PA</b> <b>246 N Washington St Rockville, MD 20850</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE 6mths</b>				
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)				
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
	28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28c. Injury at Work?		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number <b>DD041218</b>		29d. Date signed (Month, Day, Year) <b>01/08/04</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mr. Charles Harrison, MD 6001 Muncaster Mill Rd Rockville, MD 20850</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01633

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Ginette Alice Maria Poenack</b>		2. Date of Death Month <b>Jan.</b> Day <b>4</b> Year <b>2004</b>		3. Time of Death <b>9:45P M</b>	
4a. Facility Name (If not institution, give street and number) <b>7420 Westlake Terrace #1302</b>		4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>579-42-6604</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>March 11, 1930</b>		9. Birthplace (State or Foreign Country) <b>France</b>			
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <b>7420 Westlake Terrace #1302</b>		10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Hair Stylist</b>		16b. Kind of Business/Industry <b>Private</b>	
17. Father's Name (First, Middle, Last) <b>Marcel Dominique Valoatto</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Maire Chapelet</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Viviane Durand (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Plan Ravier BP16 73110 La Rochette, France</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Location - City or Town, State <b>Jan. 7, 2004 Beltsville, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rapp Funeral And Cremation Services 933 Gist Avenue Silver Spring, MD 20910</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lung Cancer</b>					
23b. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
Approximate Interval Between Onset and Death <b>2 Years</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D29675</b>		29d. Date signed (Month, Day, Year) <b>Jan. 6, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ralph Boccia, M.D. 6420 Rockledge Dr. Suite.4100 Bethesda M.D. 20817</b>					
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01634

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

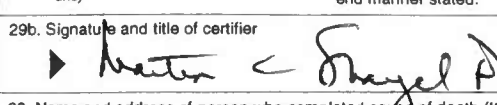
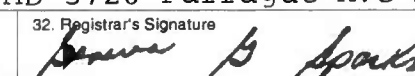
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>FLORENCE POWELL</b>		2. Date of Death Month <b>Jan.</b> Day <b>4</b> , Year <b>2004</b>		3. Time of Death <b>5:30AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Randolph Hills Nursing Home</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>
5. Social Security Number <b>220-30-5718</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 26, 1912</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Columbia</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>6536 Quiet House</b>		10f. Zip Code <b>21045</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>Home</b>	
17. Father's Name (First, Middle, Last) <b>Marshall Powell</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Thompson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mary Myers - Cousin</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6536 Quiet House Columbia, MD 21045</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ash Memorial Cem</b>		20c. Location - City or Town, State <b>1/9/04 Sandy Spring, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Snowden Funeral Home, PA 246 N. Washington St Rockville, MD 20850</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC CANCER -PRIMARY SITE UNKNOWN</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>MONTHS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D08944</b>		29d. Date signed (Month, Day, Year) <b>Jan. 5, 2004</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Martin Shargel, MD 3720 Farragut Ave Kensington, MD 20895</b>					
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>		32. Registrar's Signature 			

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01635

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lois Olson Pyles</b>				2. Date of Death Month Day Year <b>January 4, 2004</b>				3. Time of Death <b>10:30A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Rockville</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>468-12-6583</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 21, 1919</b>		9. Birthplace (State or Foreign Country) <b>Minnesota</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
To Be Completed by Funeral Director	10a. State <b>Maryland</b>				10b. County <b>Montgomery</b>				10c. City, Town or Location <b>Silver Spring</b>	
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>11805 Selfridge Road</b>				10f. Zip Code <b>20906</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Legal Secretary</b>	
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry <b>Law Firm</b>				17. Father's Name (First, Middle, Last) <b>Ole Olson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Esther Swenson</b>	
	19a. Informant's Name/Relationship (Type, Print) <b>Raymond E. Pyles/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11805 Selfridge Road, Silver Spring, Maryland 20906</b>				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>				20c. Location - City or Town, State <b>Rockville, Maryland</b>				21. Signature of Funeral Service Licensee <b>Robert A. Pumphrey</b>	
	22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Congestive Heart Failure</b> <b>Aortic Stenosis</b>				Approximate Interval Between Onset and Death <b>1 week</b>	
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury <b>M</b>				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and Title of certifier <b>Matthew Poterowski, MD</b>				29c. License number <b>D56652</b>				29d. Date signed (Month, Day, Year) <b>January 4, 2004</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Matthew Poterowski, MD 9901 Medical Center Drive, Rockville, MD</b>				31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>				32. Registrar's Signature <b>Benita B Sparks</b>	
	31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>				32. Registrar's Signature <b>Benita B Sparks</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01636

1- For State Registrar

Physician / Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) ROY ROTHE 2. Date of Death Month Day Year JANUARY 19, 2004 3. Time of Death 5:40AM

4a. Facility Name (If not institution, give street and number) Northwest Hospital 4b. City, Town, or Location of Death Randallstown 4c. County of Death Baltimore

5. Social Security Number 218-32-1526 6. Sex 12 M 2 F 7. Age (in yrs. last birthday) 85 Yrs. 8. Date of Birth (Month, Day, Year) Dec. 1, 1918 9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent 10a. State MD 10b. County Carroll 10c. City, Town or Location Sykesville 10d. Inside City Limits 1 Yes 2 X No

10e. Street and Number 7309 Second Ave. 10f. Zip Code 21784 10g. Citizen of What Country? U.S.A.

11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never Employed 16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Unknown

19a. Informant's Name/Relationship (Type, Print) Stephen Held 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4228 Hoffmanville Rd., Millers, MD 21102

20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematorium, or other place) Zion (Shaffer's) Lutheran Cemetery Date Jan. 22, 2004 20c. Location - City or Town, State Seven Valleys, PA

21. Signature of Funeral Service Licensee J. J. Hartenstein Mortuary, Inc. 22. Name and Address of Facility 24 Second St., New Freedom, PA 17349

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS

a. Due to (or as a consequence of): PNEUMONIA b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. J. IMPERIAL, Jr. MD - NWC

31. Date filed (Month, Day, Year) JAN 22 2004 32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2006 01637

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) ANNA FRANCES RAWLINS		2. Date of Death Month Day Year January 1 2004		3. Time of Death 1006 M	
4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
5. Social Security Number 217-14-8539		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 83 Yrs.	
8. Date of Birth (Month, Day, Year) 09-12-1920		9. Birthplace (State or Foreign Country) Delaware			
Usual Residence of Decedent					
10a. State Delaware		10b. County Sussex		10c. City, Town or Location Seaford	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 9985 Middleford Rd		10f. Zip Code 19973	
10g. Citizen of What Country? US		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home Owner	
17. Father's Name (First, Middle, Last) Norman James		18. Mother's Name (First, Middle, Maiden Surname) Clara (unknown)			
19a. Informant's Name/Relationship (Type, Print) Gordon J. rawlins - son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8526 Concord Rd, Seaford, DE 19973			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery		20c. Location - City or Town, State Seaford, DE	
21. Signature of Funeral Service Licensee John A. Cranston		22. Name and Address of Facility Cranston Funeral Home P O Box 967, Seaford, DE 19973			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severely cerebral vascular accident		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe mitral regurg. DM Seizure syndrome		Approximate Interval Between Onset and Death 2 days 5 yrs 5 yrs 2 wks	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier John H. McLean		29c. License number D25209	
29d. Date signed (Month, Day, Year) 1-01-2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John McLean, M.D. 100 E. CARROLL ST. SALISBURY MD 21801			
31. Date filed (Month, Day, Year) JAN 05 2004		32. Registrar's Signature Benjamin B. Sparks			

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

amend 20 per F.H. 9827

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death 1/22/04 KB

Reg. No. 2004 01638

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

GIRL ROZALJA ROZIN

2. Date of Death

January 4, 2004

3. Time of Death

11:10 AM

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Ctr.

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

NONE

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

January 4, 2004

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location  
BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6 DEAVEN CO

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INFANT

16b. Kind of Business/Industry

INFANT

17. Father's Name (First, Middle, Last)

JEAN

ROZIN

18. Mother's Name (First, Middle, Maiden Surname)

ROZALJA PATASHNIKOVA

19a. Informant's Name/Relationship (Type, Print)

G.B.M.C. PATASHNIKOVA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6701 N. CHARLES ST. TOWSON, MD. 21204

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crematory

Date

1/8/04

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

William R. Andrews

22. Name and Address of Facility

Henry W. Jenkins & Sons Co.  
16724 York Rd. Monkton, MD. 21111

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe Prematurity

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chorioamnionitis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William V. Lungen

29c. License number

D26112

29d. Date signed (Month, Day, Year)

1-04-24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greater Baltimore Medical Center 6701 N. Charles St 21204

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Rozin, Girl Rozalin  
Baltimore, Maryland 21215-0036

2006-2  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01639

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ann Johnson Rullman</b>				2. Date of Death Month Day Year <b>January 7, 2004</b>				3. Time of Death M <b>8:41 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>				4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>219-32-7975</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 18, 1936</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>7 Bristol Circle</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>Administrative Assistant</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Insurance</b>				16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <b>James Brainard Johnson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Elizabeth Wirtz</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Walter Rullman / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3501A Lochearn Court Pasadena, Maryland 21122</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Anne's Cemetery</b>		Date <b>1/12/2004</b>		20c. Location - City or Town, State <b>Annapolis, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Michael Sloan</b>				22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pneumococcal Pneumonia</b> Due to (or as a consequence of): a. b. c. d. Approximate Interval Between Onset and Death <b>&gt; 5 day</b>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive lung disease</b>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Dr. J. Peterson</b>				29c. License number <b>024804</b>		29d. Date signed (Month, Day, Year) <b>1-07-2004</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert T. Peterson MD</b> <b>ATMC Annapolis Md 21401</b>										
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>				32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 905A.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01640

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Roy Clifford Rhodes</b>				2. Date of Death Month <b>January</b> Day <b>9</b> Year <b>2004</b>		3. Time of Death <b>1:50 A M</b>	
4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>225-54-8528</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 26, 1940</b>	
9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Davidsonville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1434 Governor Bridge Rd.</b>		10f. Zip Code <b>21035</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1958-66</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>Security</b>	
17. Father's Name (First, Middle, Last) <b>Albert Leonard Rhodes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Gilliam</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Joyce F. Rhodes/ Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1434 Governor Bridge Rd., Davidsonville, MD 21035</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Kalas Crematory</b>		Date <b>1-10-04</b>		20c. Location - City or Town, State <b>Edgewater, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lung Cancer</b>						Approximate Interval Between Onset and Death <b>10 months</b>	
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Due to (or as a consequence of): a. b. c. d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>038445</b>		29d. Date signed (Month, Day, Year) <b>1/9/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ira Weinstein 600 Bridge Ave, Annapolis, MD</b>							
31. Date filed (Month, Day, Year) <b>JAN 12 2004</b>		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01641

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Dora Annette Ring

2. Date of Death

January 2, 2004

3. Time of Death

5:45 PM<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

8987 James Ring Road

4b. City, Town, or Location of Death

Westover

4c. County of Death

Somerset

5. Social Security Number

219-36-5175

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

04/15/1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Westover

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8987 James Ring Road

10f. Zip Code

21871

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Farm

17. Father's Name (First, Middle, Last)

Paul Mitchell Davis

18. Mother's Name (First, Middle, Maiden Surname)

Ella Beatrice Johnson

19a. Informant's Name/Relationship (Type, Print)

Karon Bowden/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30236 Sharon Drive, Princess Anne, MD 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beechwood Cemetery

Date

01/06/2004

20c. Location - City or Town, State

Princess Anne, MD

21. Signature of Funeral Service Licensee

M00295

22. Name and Address of Facility

Hinman Funeral Home  
11673 Somerset Ave., Princess Anne, MD 21853

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Metastatic Lung Cancer to Brain

Approximate Interval Between Onset and Death

2 month

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D36576

29d. Date signed (Month, Day, Year)

1/6/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald P. T. H. MD 560 Riverside Drive Salisbury MD 21801

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01642

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3041

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>James Hollister Robertson</b>		2. Date of Death Month <b>January</b> Day <b>3</b> , Year <b>2004</b>		3. Time of Death <b>11:08A M</b>	
4a. Facility Name (If not institution, give street and number) <b>4610 Chevy Chase Boulevard</b>		4b. City, Town, or Location of Death <b>Chevy Chase</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>342-20-6594</b>	6. Sex <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 20, 1908</b>
9. Birthplace (State or Foreign Country) <b>Minnesota</b>					
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Chevy Chase</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>4610 Chevy Chase Boulevard</b>		10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>World War II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operations Officer</b>		16b. Kind of Business/Industry <b>Central Intelligence Agency</b>			
17. Father's Name (First, Middle, Last) <b>James Gilmore Robertson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Antoinette Lewis</b>		
19a. Informant's Name/Relationship (Type, Print) <b>James C. Robertson/Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19740 Greenside Terrace, Montgomery Village, MD 20886</b>		
20a. Method of Disposition <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Grove Cemetery</b>		20c. Location - City or Town, State <b>Rushford, Minnesota</b>	
21. Signature of Funeral Service Licensee <b>Daniel E. Perry</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <b>Uremia</b>					
Due to (or as a consequence of):					
b. <b>Chronic Renal Failure</b>					
Due to (or as a consequence of):					
c. <b>Obstructive Uropathy</b>					
Due to (or as a consequence of):					
d. <b>Nephrolithiasis</b>					
IF FEMALE:					
23b. Was decedent pregnant in the past 12 months? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>9</b> <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <b>1</b> <input type="checkbox"/> Live birth <b>2</b> <input type="checkbox"/> Fetal death <b>3</b> <input type="checkbox"/> Ectopic pregnancy <b>4</b> <input type="checkbox"/> Pregnant at time of death <b>5</b> <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<b>Advanced Malnutrition</b>					
<b>Congestive Heart Failure</b>					
<b>Metastatic Prostate Carcinoma</b>					
25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)			
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Daniel E. Perry</b>		29c. License number <b>D47867</b>		29d. Date signed (Month, Day, Year) <b>January 5, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Oney Zuniga, M.D. 4701 Randolph Road, #101, Rockville, Maryland 20852-2257</b>					
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature <b>Benjamin B Sparks</b>			



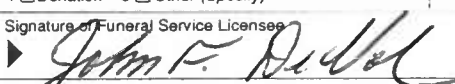
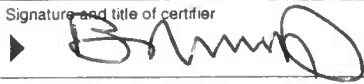

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01643

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Mary Reynolds				2. Date of Death Month Day Year January 5, 2004		3. Time of Death 3:10 A.M.	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Home			4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 577-01-0717		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 22, 1906	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Md.		10b. County Prince George's		10c. City, Town or Location Hyattsville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 5805 Queens Chapel Road		10f. Zip Code 20782		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Work		16b. Kind of Business/Industry Telephone Company			
	17. Father's Name (First, Middle, Last) Joseph Anthonyv Dunn				18. Mother's Name (First, Middle, Maiden Sumame) ( Unavailable ) Mountney			
	19a. Informant's Name/Relationship (Type, Print) Edward Love / Attorney				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4816 Moorland Lane Bethesda, Md. 20814			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State January 8, 2004 Silver Spring, Md.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave. N.W. Washington, D.C. 20007			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiopulmonary Failure Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): c. Atrial Fibrillation Due to (or as a consequence of): d. Anorexia							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Renal Failure Pulmonary Fibrosis						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number 51520		29d. Date signed (Month, Day, Year) January 6, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, M.D. 1328 Southern Ave. S.E. #310 Washington, D.C. 20032								
31. Date filed (Month, Day, Year) JAN 07 2004		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01644

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

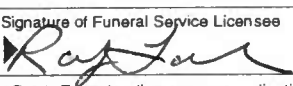

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Rozelyn F. Riley</b>		2. Date of Death Month Day Year <b>January 6, 2004</b>		3. Time of Death <b>6:17 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>5702 Maiden Lane</b>		4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>578-34-0501</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Feb. 21, 1912</b>	9. Birthplace (State or Foreign Country) <b>Georgia</b>	
Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10e. Street and Number <b>5702 Maiden Lane</b>		10f. Zip Code <b>20817</b>	10g. Citizen of What Country? <b>United States</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	
16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Robert E. Falligant</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Johanna Corinne Bailey</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Susan A. Riley/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5704 Maiden Lane, Bethesda, Maryland 20817</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>	
21. Signature of Funeral Service Licensee  <b>M00198</b>		22. Name and Address of Facility <b>Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Advanced Endstage Dementia</b> Due to (or as a consequence of): <b>b. Cerebral Atherosclerosis</b> Due to (or as a consequence of): <b>c. Hypertension</b> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>Old</b> <b>Old</b> <b>Old</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier  <b>Loreto Albiol, M.D.</b>		29c. License number <b>D31319</b>		29d. Date signed (Month, Day, Year) <b>January 6, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Loreto Albiol, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814</b>					
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature 			

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01645

Certificate of Death

Reg. No.

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>VINCENT JOSEPH RYBA, JR.</b>				2. Date of Death Month <b>JAN.</b> Day <b>17</b> Year <b>2004</b>		3. Time of Death <b>9:15 p<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>WILSON HEALTH CARE</b>				4b. City, Town, or Location of Death <b>GAITHERSBURG</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>103-24-3639</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 9 1929</b>	9. Birthplace (State or Foreign Country) <b>NY</b>
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>GERMANTOWN</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>18501 KINGSHILL ROAD</b>				10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MATHEMATICIAN</b>		16b. Kind of Business/Industry <b>RESEARCH &amp; DEVELOP.</b>	
17. Father's Name (First, Middle, Last) <b>VINCENT RYBA</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CASMIRA KIEDROWSKI</b>			
19a. Informant's Name/Relationship (Type, Print) <b>ANN SNYDER / DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 BOOKHAM LA., GAITHERSBURG, MD 20877</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. MARY'S CEMET.</b>		Date <b>1/22/04</b>		20c. Location - City or Town, State <b>BARNESVILLE, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PARKINSON'S DISEASE</b>							
23b. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D31563</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 19, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHARLES M. BENNER MD, 10801 LOCKWOOD DRIVE #205, SILVERSPRING 20901</b>							
31. Date filed (Month, Day, Year) <b>JAN 22 2004</b>				32. Registrar's Signature 			

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01646

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SYLVESTER JAMES STANLEY</b>				2. Date of Death Month <b>January</b> Day <b>03</b> Year <b>2004</b>		3. Time of Death <b>1119</b> M	
	4a. Facility Name (If not institution, give street and number) <b>The Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>218-40-5970</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 2, 1942</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>826 Robbin Street</b>		10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Grain Lift Operator</b>		16b. Kind of Business/Industry <b>Perdue</b>			
	17. Father's Name (First, Middle, Last) <b>John R. Stanley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Margret Wilson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Brenda Stanley / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1003 Central Ave., Cambridge, Maryland 21613</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Airey's Cemetery</b>		Date <b>01/10/2004</b>		20c. Location - City or Town, State <b>Cambridge, Maryland</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bennie Smith Funeral Home 524 Race Street, Cambridge, Maryland 21613</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): <b>RENAL FAILURE</b> Due to (or as a consequence of): <b>PNEUMONIA</b> Due to (or as a consequence of): <b>CARDIAC ARRHYTHMIA</b>							
	Approximate Interval Between Onset and Death <b>Weeks</b> <b>Weeks</b> <b>Weeks</b> <b>Weeks</b>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month <b>01</b> Day <b>10</b> Year <b>2004</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b> <b>ANEMIA</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>00057067</b>		29d. Date signed (Month, Day, Year) <b>01/05/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAMIAN SOOKAL 607 BUTCHMAN'S LANE, EASTON MD 21601</b>								
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01647

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified in writing.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAULINE WRIGHT YOUNG SANDLASS</b>		2. Date of Death Month <b>JANUARY</b> Day <b>3</b> Year <b>2004</b>		3. Time of Death <b>6:30AM M</b>
	4a. Facility Name (If not institution, give street and number) <b>HEARTFIELDS</b>		4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>
Funeral Director	5. Social Security Number <b>214-40-4404</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>AUG 11 1911</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	10a. State <b>MD</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>ROYAL OAK</b>
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>25619 MOORES RD</b>		10f. Zip Code <b>21662</b>
	10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TEACHER</b>		16b. Kind of Business/Industry <b>ELEMENTARY EDUCATION</b>		17. Father's Name (First, Middle, Last) <b>JAMES BLAINE WRIGHT</b>
	18. Mother's Name (First, Middle, Maiden Surname) <b>EDITH BELL</b>		19a. Informant's Name/Relationship (Type, Print) <b>RICHARD L. COUNTS III/PER. REP.</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO BOX 1209 EASTON, MD 21601</b>
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATION CTR.</b>		20c. Location - City or Town, State <b>1-7-2004 STEVENSVILLE, MD</b>
	21. Signature of Funeral Service Licensee <b>JOHN R. MERCERON</b>		22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME PA</b>		22. Name and Address of Facility <b>200 S. HARRISON ST EASTON, MD 21601</b>
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>2 years</b>		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) 9 Unknown		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ASSISTED LIVING</b>	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Ludwig J. Eglsefer, III M.D.</b>	
29c. License number <b>D31466</b>		29d. Date signed (Month, Day, Year) <b>1/6/04</b>		30. Name and address of person who completed cause of death (Item 28a) (Type, Print) <b>LUDWIG J. EGLSEDER, III M.D. 606 DUTCHMANS LANE EASTON, MD 21601</b>	
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature <b>Barbara D. Spivey</b>			



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01648

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard William Siebecker				2. Date of Death Month Day Year JANUARY 6, 2004		3. Time of Death 2:15 a M	
	4a. Facility Name (If not institution, give street and number) 59 BARRETT ROAD				4b. City, Town, or Location of Death CONOWINGO		4c. County of Death CECIL	
Funeral Director	5. Social Security Number 227-06-8799		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 35 Yrs.	8. Date of Birth (Month, Day, Year) April 13, 1968	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Cecil		10c. City, Town or Location Conowingo		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 59 Barrett Road				10f. Zip Code 21918		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Two Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bio Medical Engineer		16b. Kind of Business/Industry Bayer Pharmaceutical Company Baltimore, Maryland			
	17. Father's Name (First, Middle, Last) James Lewis Siebecker				18. Mother's Name (First, Middle, Maiden Surname) Margaret Mackrel			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Stephanie Siebecker (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 Barrett Road, Conowingo, Maryland 21918			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co., Inc.		Date 01/11/04		20c. Location - City or Town, State West Chester, Pennsylvania	
	21. Signature of Funeral Service Licensee Theodore M. King, Sr.				22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Anterior wall Myocardial Infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE			
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 4/6/04		28b. Time of Injury 0159 HRS		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home		28d. Describe how injury occurred Subject shot self		28f. Location (Street and Number or Rural Route Number, City or Town, State) 59 Barrett Road, Conowingo, Maryland			
State Registrar	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Theodore M. King, Sr.		29c. License number OCME	
	29d. Date signed (Month, Day, Year) JANUARY 6, 2004				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. King, 111 Penn Street, Baltimore, Maryland 21201			
	31. Date filed (Month, Day, Year) JAN 08 2004				32. Registrar's Signature D. Sparks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01649

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AILEEN SARMAST

2. Date of Death

January 8, 2004

3. Time of Death

4:00 p.<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

212-08-4436

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

35

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 27, 1968

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Annes

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

612 Old Love Point Road

10f. Zip Code

21666

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Message Therapist

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Victor Sarmast

18. Mother's Name (First, Middle, Maiden Surname)

Adrienne Wiltz

19a. Informant's Name/Relationship (Type, Print)

Adrienne Rogers (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

407 N. Main Street Edinburg, Virginia 22824

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Center

Date

January 14, 2004

20c. Location - City or Town, State

Chester, Maryland

21. Signature of Funeral Service Licensee

M00982

22. Name and Address of Facility

Adams Funeral &amp; Memorial Care

814 Bestgate Road Annapolis, Maryland 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Pneumococcal pneumonia with sepsis*

Approximate Interval Between Onset and Death

&gt; 7 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARDS  
bilateral CVA  
DIC

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D24804

29d. Date signed (Month, Day, Year)

1-08-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert T Peterson ATMC Annapolis Md 21401

31. Date filed (Month, Day, Year)

JAN 14 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Baltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: Alter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01650

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Marshall Schmier</b>		2. Date of Death Month <b>January</b> Day <b>9</b> Year <b>2004</b>		3. Time of Death <b>10:45 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Genesis Eldercare Spa Creek Center</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>216-20-6497</b>	6. Sex <b>152 M</b> 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 11, 1926</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Crofton</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1630 Eton Way</b>		10f. Zip Code <b>21114</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-45</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner</b>		16b. Kind of Business/Industry <b>Art Gallery</b>	
17. Father's Name (First, Middle, Last) <b>William Schmier</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Fram</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Morris Schmier/son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2085 Lake Grove Lane Crofton, MD 21114</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Crematory</b>		20c. Location - City or Town, State <b>1/12/2004 Baltimore, MD</b>	
21. Signature of Funeral/Service Licensee <b>Todd E. Liller</b>		22. Name and Address of Facility <b>John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Renal Cell Carcinoma</b>					Approximate Interval Between Onset and Death <b>3M</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Dr. J. Spruill</b>		29c. License number <b>033036</b>		29d. Date signed (Month, Day, Year) <b>1/9/2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gary J Spruill 2107 N. Potomac Drive Chesapeake, MD 21615</b>					
31. Date filed (Month, Day, Year) <b>JAN 12 2004</b>		32. Registrar's Signature <b>John A. Spruill</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01651

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Francis Allen Sweeney</b>			2. Date of Death Month <b>Jan.</b> Day <b>3</b> Year <b>2004</b>		3. Time of Death <b>6:30<sup>PM</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>			4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>216-38-5053</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 24, 1937</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Oakland</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>1551 Mayhew Inn Road</b>			10f. Zip Code <b>21550</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>Owner</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>Marina</b>		
	17. Father's Name (First, Middle, Last) <b>Harold Francis Sweeney</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Dora Viola Martin</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Alan L. Sweeney/son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1201 Glen Cove Parkway, Vallejo, Ca. 94591</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Omega Crematory</b>		20c. Location - City or Town, State <b>1/6/04 Morgantown, WV</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550</b>				
	23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Colon Cancer &amp; metastases</b>						
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>severe septicaemia</b>							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined							
28a. Date of Injury (Month, Day Year)							
28b. Time of Injury <b>M</b>							
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and Title of Certifier 							
29c. License number <b>1203459</b>							
29d. Date signed (Month, Day, Year) <b>1/4/2004</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. ESPINA, MD 902 Seton Drive, Cumberland, Md</b>							
31. Date filed (Month, Day, Year) <b>JAN 05 2004</b>							
32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01652

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harold Stansberry</b>				2. Date of Death Month Day Year <b>January 7, 2004</b>				3. Time of Death <b>9:30 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>426 Heather Ridge Drive</b>				4b. City, Town, or Location of Death <b>Frederick</b>				4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>244-50-1859</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 7, 1934</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>		
	10a. State <b>Maryland</b>				10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No		
10e. Street and Number <b>426 Heather Ridge Drive</b>				10f. Zip Code <b>21702</b>				10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>1953-1957</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanical Designer</b>				16b. Kind of Business/Industry <b>Drafting</b>			
17. Father's Name (First, Middle, Last) <b>James Edward Stansberry</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sibbie Emenline Barker</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Della Mae Stansberry/ Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>426 Heather Ridge Drive, Frederick, MD 21702</b>							
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Geo. Wash. University Medical Center</b>				Date <b>January 7 2004</b>		20c. Location - City or Town, State <b>Washington, D.C.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ASCVD</b>				a. Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>10 years</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1</b> Yes <b>2</b> No <b>9</b> Unknown				23c. If yes, outcome of pregnancy <b>1</b> Live birth <b>2</b> Fetal death <b>4</b> Pregnant at time of death <b>5</b> Other (specify) <b>9</b> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown			
								24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No			
								24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No			
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)							
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D-31912</b>		29d. Date signed (Month, Day, Year) <b>1/08/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JULIO MENDOZA MD, 1564 OPOSSUM TOWN BLVD, FREDERICK, MD 21702</b>											
31. Date filed (Month, Day, Year) <b>JAN -9 2004</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 905a.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01653

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Sarah Elizabeth Summers

2. Date of Death

January 3, 2004

3. Time of Death

3:03P M

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

217-28-5962

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 28, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Jefferson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3324 Jefferson Pike

10f. Zip Code

21755

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Assembler

16b. Kind of Business/Industry

Optical

17. Father's Name (First, Middle, Last)

Roy A. Cline

18. Mother's Name (First, Middle, Maiden Surname)

Clara B. Castle

19a. Informant's Name/Relationship (Type, Print)

Charles H. Summers / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3324 Jefferson Pike Jefferson, Maryland 21755

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

1-6-04

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Courtney Mathis

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
10 days

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Dementia

Multiple Myeloma

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Menon, M.D.

29c. License number

00055793

29d. Date signed (Month, Day, Year)

1-4-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

610 Solares Ct, Frederick MD 21703

Suresh K. Menon, M.D.

31. Date filed (Month, Day, Year)

JAN - 5 2004

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01654

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emma Louise Smith			2. Date of Death Month Day Year January 6, 2004		3. Time of Death 1904 M	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital			4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579-20-5972	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	8. Date of Birth (Month, Day, Year) Aug. 20, 1921	9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent						
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Upper Marlboro		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 9017 Columbine Lane			10f. Zip Code 20772		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper		16b. Kind of Business/Industry Private		
17. Father's Name (First, Middle, Last) Robert L. McElwee				18. Mother's Name (First, Middle, Maiden Surname) Gertie McCullough			
19a. Informant's Name/Relationship (Type, Print) William T. Thompson (Nephew)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9017 Columbine Lane Upper Marlboro, Maryland 20772			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 2004 Cheltenham, Maryland		20c. Location - City or Town, State Jan. 13, 2004		20d. Date	
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Upper GI. bleeding Due to (or as a consequence of): b. dyspepsia toxicity Due to (or as a consequence of): c. Atrial fibrillation Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 24hr 24hr							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature]		29c. License number D-24535		29d. Date signed (Month, Day, Year) 01.07.04			
30. Name and address of person who completed cause of death (If not 23a) (Type, Print) Laxmi N. Berwa MD 7700 Old Branch Ave. #C101 Clinton, Maryland 20735							
31. Date filed (Month, Day, Year) JAN 08 2004		32. Registrar's Signature [Signature]					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #26 per VER:ALG828 2/21/04 Certificate of Death

Reg. No.

2004 01655

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carl Sanford Shyman</b>						2. Date of Death Month Day Year <b>January 5, 2004</b>		3. Time of Death <b>10:03A. M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>				4b. City, Town, or Location of Death <b>Olney</b>			4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>534-12-4450</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 31, 1925</b>		9. Birthplace (State or Foreign Country) <b>Seattle, Wash.</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>13713 Mills Avenue</b>				10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager/Engineer</b>			16b. Kind of Business/Industry <b>Westinghouse Aero Space</b>		
	17. Father's Name (First, Middle, Last) <b>Irving Shyman</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Vivian Lurie</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Helouise J. Shyman -wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13713 Mills Avenue Silver Spring, Maryland 20904</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Memorial Gardens</b>			Date <b>1/7/2004</b>		20c. Location - City or Town, State <b>Olney, Maryland</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Acute MI</b> Due to (or as a consequence of): b. <b>CAD</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>60 min</b> <b>420</b>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number <b>BC1082039</b>		29d. Date signed (Month, Day, Year) <b>1/5/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Matthew Connolly, M.D. 18109 Prince Philip Dr., #225 Olney, Maryland 20832</b>										
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01656

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGIE TAUHEEDA SALEEM

2. Date of Death

Jan. 3, 2004

3. Time of Death

9:20a M

4a. Facility Name (If not institution, give street and number)

4739 68th Pl.

4b. City, Town, or Location of Death

Landover Hills

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

578-28-9523

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 17, 1914

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Geo.

10c. City, Town or Location

Landover Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4739 68th Pl.

10f. Zip Code

20784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Chef

17. Father's Name (First, Middle, Last)

John Allen

18. Mother's Name (First, Middle, Maiden Surname)

Endie Smith

19a. Informant's Name/Relationship (Type, Print)

Veronica Raynor- Grand-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4739 68th Pl, Landover Hills, Maryland 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Geo. Wash. Cemet.

Date

1-8-04

20c. Location - City or Town, State

Adelphi, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Universal II Mortuary Inc.  
411 Kennedy St, N.W., Wash, D.C. 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Breast Carcinoma

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D0059633

29d. Date signed (Month, Day, Year)

01/05/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glen Jacob, MD 1221 Mercantile La, Largo, Md. 20774

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01657

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>GERTRUDE J. SCHILLER</b>		2. Date of Death Month <b>JANUARY</b> Day <b>5</b> Year <b>2004</b>		3. Time of Death <b>11:40 A M</b>	
4a. Facility Name (If not institution, give street and number) <b>6001 Muncaster Mill Road-Casey House</b>		4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>051 10 8211</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Sept. 25, 1918</b>	9. Birthplace (State or Foreign Country) <b>New York</b>	
Usual Residence of Decedent					
10a. State <b>Md.</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Gaithersburg</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>23713 Eli Lane</b>		10f. Zip Code <b>20882</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Thomas Lyons</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Durney</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Jean F. Smedira / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23713 Eli Lane, Gaithersburg, Md. 20882</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Cemetery</b>		20c. Location - City or Town, State <b>Rockville, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of): <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					Approximate Interval Between Onset and Death <b>1 YEAR</b>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ADVANCED DEMENTIA</b>					23d. Date of delivery Month Day Year
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and Title of certifier 		29c. License number <b>00041218</b>		29d. Date signed (Month, Day, Year) <b>01/05/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHARLES HARRISON, M.D. 1355 PICCARD DRIVE, ROCKVILLE, MD. 20850</b>					
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01658

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Jayaraj Sathyasheelappa

2. Date of Death

1-1-04

Day Year

3. Time of Death

12:35 P.M.

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

215-62-6030

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-27-1935

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6625 61st Pl.

10f. Zip Code

20731

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: East Indian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Hotel Industry

17. Father's Name (First, Middle, Last)

Rangappa Sathyasheelappa

18. Mother's Name (First, Middle, Maiden Surname)

Saramma Marappa

19a. Informant's Name/Relationship (Type, Print)

Vinaya Sathyasheelappa - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6625 61st Pl. Riverdale, MD 20731

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Crem.

Date

1-5-04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

► *[Signature]*

22. Name and Address of Facility Hines-Rinaldi F. H.

11800 New Hampshire Ave., Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Sepsis

Due to (or as a consequence of):

Coronary artery disease

Due to (or as a consequence of):

Cerebrovascular stroke

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_\_  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

► *[Signature]* M.D. Patel Jayanthi

29c. License number

D052586

29d. Date signed (Month, Day, Year)

1/1/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patel Jayanthi, M. D. c/o Holy Cross Hosp. 1500 Forest Glen Rd. Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

► *[Signature]*State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

## Certificate of Death

Reg. No. 2004 01659

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albert M. Schindler				2. Date of Death Month Day Year January 1, 2004				3. Time of Death 12:30 A.M.	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-28-2111		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 17, 1927		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 3005 S. Leisure World Blvd., Apt. 101				10f. Zip Code 20906		10g. Citizen of What Country? U. S. A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW 2 Army		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant			16b. Kind of Business/Industry Dry Cleaning		
	17. Father's Name (First, Middle, Last) Julius Schindler					18. Mother's Name (First, Middle, Maiden Surname) Goldie Epstein				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Nita J. Schindler - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 S. Leisure World Blvd., Apt. 101, Silver Spring, Maryland 20906					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Gardens		Date 1/5/2004		20c. Location - City or Town, State Olney, Maryland	
	21. Signature of Funeral Service Licensee Donald S. Stottmeyer				22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Cacinoid Tumor									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Alan Schneider MD		29c. License number 40611		29d. Date signed (Month, Day, Year) 1/1/04	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Schneider 10313 Georgia Ave #306 Silver Spring MD 20902									
31. Date filed (Month, Day, Year) JAN 07 2004				32. Registrar's Signature B Sparks						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01660

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Anna Josephine Schneider</b>				2. Date of Death Month <b>January</b> Day <b>6</b> , Year <b>2004</b>		3. Time of Death <b>9:35 a M</b>	
4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>281-32-6242</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 12, 1922</b>	9. Birthplace (State or Foreign Country) <b>Germany</b>
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Germantown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>11537 Doxdam Terrace</b>				10f. Zip Code <b>20876</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Josef Volkmar</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine Bloch</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Willie Schneider/ Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11537 Doxdam Terrace, Germantown, MD 20876</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>January 10 2004</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>	
21. Signature of Funeral Service Location <i>Robert [Signature]</i>				22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Hypoxia</b> Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Chronic obstructive lung disease</b> Due to (or as a consequence of): <b>Cordioromyopathy</b>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cordioromyopathy</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death Check only one Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D0060168</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 7<sup>th</sup> 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ASEFA MEKONNEN Suburban Hospital</b>							
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Schneider, Anne- 0935 Jan 6, '04

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01661

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Theresa Frances Schrider

2. Date of Death

Month Day Year  
January 5, 2004

3. Time of Death

9:40 P M

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-40-9990

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 24, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1131 University Blvd. W., #710

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

John B. Schrider

18. Mother's Name (First, Middle, Maiden Surname)

Mary V. Lynch

19a. Informant's Name/Relationship (Type, Print)

Alfred M. Schrider/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8372 Reservoir Road, Fulton, MD 20759

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Gate of Heaven  
Cemetery

Date

January 9  
2004

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Ann Marie Parker

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.  
500 University Blvd. W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Sacral Decubiti

Due to (or as a consequence of):

c. Parkinson's Disease

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Connie Le

M.D., CONNIE, MD

29c. License number

D60619

29d. Date signed (Month, Day, Year)

January 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Connie Le, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

Connie Le

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2004 01662

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Harry Shandelson		2. Date of Death Month Day Year January 5, 2004		3. Time of Death 4:00 A M	
4a. Facility Name (If not institution, give street and number) Montgomery General Hospital		4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
5. Social Security Number 359-10-5107	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	8. Date of Birth (Month, Day, Year) Feb 2, 1914	9. Birthplace (State or Foreign Country) Illinois	
Usual Residence of Decedent					
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 3005 S. Leisure World Blvd., #626		10f. Zip Code 20906		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Deputy Regional Commissioner		16b. Kind of Business/Industry Social Security Admin.	
17. Father's Name (First, Middle, Last) Benjamin Shandelson		18. Mother's Name (First, Middle, Maiden Surname) Rose Efrod			
19a. Informant's Name/Relationship (Type, Print) Ruth Shandelson, wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 S. Leisure World Blvd, #626 Silver Spring, MD 20906			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Garden 1/7/04		20c. Location - City or Town, State Olney, Maryland	
21. Signature of Funeral Service Licensee Donald C. Stottlenger		22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seizure Due to (or as a consequence of): History of Meningioma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease Hypertension		Approximate Interval Between Onset and Death 1 hour 9 years			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Samuel Maller, M.D.		29c. License number D500612	
29d. Date signed (Month, Day, Year) January 5, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Maller, M.D., 3305 N. Leisure World Blvd., Silver Spring, MD 20906					
31. Date filed (Month, Day, Year) JAN 07 2004		32. Registrar's Signature Sparks			



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01663

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Selma Small

2. Date of Death

January 7 2004

Day Year

3. Time of Death

8:00 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

817 Quince Orchard Blvd. #23

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

096-12-2415

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 30, 1923

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

817 Quince Orchard Blvd. #23

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bank Teller

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Hyman Kislewitz

18. Mother's Name (First, Middle, Maiden Surname)

Rose Levy

19a. Informant's Name/Relationship (Type, Print)

Michael Small (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17 Native Dancer Ct. Gaithersburg, Md. 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crem.

Date

Jan. 8,  
2004

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home, 10 East  
Deer Park Drive, Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. Phyllis Schreiner

29c. License number

D2650

29d. Date signed (Month, Day, Year)

January 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Phyllis Schreiner M.D. 6000 Executive Blvd. #300 Rockville, Md. 20852

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

Benita B Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01664

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Starcke Helle 12/04 0033 AM

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Helle Starcke</b>		2. Date of Death Month Day Year <b>January 2, 2004</b>		3. Time of Death <b>12:53A<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>		4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>052-28-3818</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>June 14, 1929</b>	9. Birthplace (State or Foreign Country) <b>Denmark</b>	
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Rockville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>12732 Veirs Mill Road #103</b>		10f. Zip Code <b>20853</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Entomologist</b>		16b. Kind of Business/Industry <b>Smithsonian Institute</b>			
17. Father's Name (First, Middle, Last) <b>Gustav Starcke</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Gudrun Strandholm</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Bente King/Sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8 Hillcrest Road, Ithaca, New York 14850</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Acute myocardial infarction</b>		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
23f. Approximate Interval Between Onset and Death <b>4 days</b>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Signature and title of certifier <b>Sharon Turban M.D.</b>		29b. License number <b>MD D56439</b>		29c. Date signed (Month, Day, Year) <b>01/02/2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Sharon Turban 9901 Medical Center Dr., Rockville, MD 20850</b>					
31. Date filed (Month, Day, Year) <b>JAN 05 2004</b>		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01665

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nell P. Stovall

2. Date of Death

January 7, 2004

3. Time of Death

2:00 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

267-32-2106

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 11, 1924

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14628 Kelmscot Drive

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Business Office Manager

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

George Dewey Pinholster

18. Mother's Name (First, Middle, Maiden Surname)

Delah Bielling

19a. Informant's Name/Relationship (Type, Print)

Jerome D. Stovall/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14628 Kelmscot Drive, Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

January 12, 2004

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Ave., Rockville, MD 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Atrial Fibrillation

a. Due to (or as a consequence of):

Congestive Heart Failure

b. Due to (or as a consequence of):

Septicemia

c. Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D47330

29d. Date signed (Month, Day, Year)

January 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas V. Joseph, M.D. 50 West Edmonston Drive, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

JAN 09 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01666

1- For  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Dorothy Evelyn Taylor</b>		2. Date of Death Month Day Year <b>JANUARY 05, 2004</b>		3. Time of Death <b>10:35 A<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
5. Social Security Number <b>215-16-4086</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 26, 19</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>Md</b>	10b. County <b>Allegany</b>	10c. City, Town or Location <b>Barton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>23107 Rainbow Lane</b>		10f. Zip Code <b>21521</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Tire &amp; Fiber Ind.</b>	
17. Father's Name (First, Middle, Last) <b>John Green</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Alda Broadwater</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Vickie Harvey/Dau</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24600 Beeman Rd. Barton, Md 21521</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LaUREL Hill Cem</b>		20c. Location - City or Town, State <b>1/7/04 Moscow, Md</b>	
21. Signature of Funeral Service Licensee <b>F. Wayne Boul</b>		22. Name and Address of Facility <b>Boal Funeral Home, 111 Church St Westernport, Md. 21562</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA, RIGHT MIDDLE AND LOWER LOBE</b>		Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>2 WEEKS</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b>		Due to (or as a consequence of):			
<b>c.</b>		Due to (or as a consequence of):			
<b>d.</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Hobertson Bane</b>		29c. License number <b>D14865</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 5<sup>TH</sup> 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. ROBUSTIANO BARRERA 500 MEMORIAL AVENUE, STE 201 CUMBERLAND, MARYLAND 21502</b>					
31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01667

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Jackie Theodore Thomas</u>				2. Date of Death Month <u>1</u> Day <u>5</u> Year <u>04</u>		3. Time of Death <u>2:00 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>284 Humberson Road</u>				4b. City, Town, or Location of Death <u>Friendsville</u>		4c. County of Death <u>Garrett</u>	
Funeral Director	5. Social Security Number <u>172-28-0195</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>68</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>Aug. 12, 1935</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>	
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>Garrett</u>		10c. City, Town or Location <u>Friendsville</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <u>284 Humberson Road</u>				10f. Zip Code <u>21531</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4or 5+) <u></u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Owner/Operator</u>		16b. Kind of Business/Industry <u>Used Car/Retail</u>		
17. Father's Name (First, Middle, Last) <u>George Kenneth Thomas</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Sarah E. Fosbrink</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Mary K. Thomas/Wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>284 Humberson Road; Friendsville, MD 21531</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Sand Spring Cemetery</u>		Date <u>Jan. 7, 2004</u>		20c. Location - City or Town, State <u>Friendsville, MD</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Newman Funeral Homes, P.A. P.O. Box 275 Grantsville, Maryland 21536</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>End stage Cardiac myopathy</u> Due to (or as a consequence of): <u>Coronary artery disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>CHF Class IV</u> <u>Chronic Renal Insufficiency</u> <u>CV A</u>								Approximate Interval Between Onset and Death <u>year</u>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month <u></u> Day <u></u> Year <u></u>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHF Class IV</u> <u>Chronic Renal Insufficiency</u> <u>CV A</u>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <u></u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>H26154</u>		29d. Date signed (Month, Day, Year) <u>1/5/04</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Paul Daniel Miller 69 Wolfe Acres Drive Oakland, MD 21552</u>								
31. Date filed (Month, Day, Year) <u>JAN 0 6 2004</u>		32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

3



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #7 per FHC8282/25/04 EW Certificate of Death

Reg. No. 2004 01668

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARION IDA TOBIN			2. Date of Death Month Day Year January 1, 2004		3. Time of Death 8:15 P M	
	4a. Facility Name (If not institution, give street and number) Sunrise Assisted Living of Frederick			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 050-07-2330		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 89 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 22, 1914
	9. Birthplace (State or Foreign Country) New Jersey		10a. State Md.		10b. County Frederick		10c. City, Town or Location Frederick
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 990 Waterford Drive		10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 3 Years +		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry None		
	17. Father's Name (First, Middle, Last) George Beck			18. Mother's Name (First, Middle, Maiden Surname) Helena Unknown			
	19a. Informant's Name/Relationship (Type, Print) Mr. Ronald G. Tobin (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1524 Beverly Court Frederick, Md. 21701			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Knolls Cemetery		Date 1-07-04		20c. Location - City or Town, State Port Washington, N.Y.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701				
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End Stage Osteoporosis Due to (or as a consequence of): b. Restrictive Lung Disease Due to (or as a consequence of): c. Diabetes Mellitus Type II Due to (or as a consequence of): d. Peripheral Vascular Disease						
	Approximate Interval Between Onset and Death Years Years Years Years						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Failure to Thrive, Severe Kyphosis Anoerxia, Cachexia Immobility Syndrome, I						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) assisted living			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number D54749		29d. Date signed (Month, Day, Year) 01 02 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Reilly, MD 801 Toll House Ave. Suite D-1 Frederick, Md. 21701							
31. Date filed (Month, Day, Year) JAN - 6 2004		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01669

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Henry Thomas

2. Date of Death

January 1, 2004

3. Time of Death

11:57 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

216-50-9927

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 10, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11805 Prices Distillery Rd

10f. Zip Code

20872

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1968-1972

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Home Improvement

17. Father's Name (First, Middle, Last)

James Williams

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Thomas

19a. Informant's Name/Relationship (Type, Print)

Esther D. Thomas- Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17418 Gallagher Way Olney, MD 20852

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Funrl. Svcs

Date

1/8/2004

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Snowden Funeral Home, PA  
246 N Washington St Rockville, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35164

29d. Date signed (Month, Day, Year)

January 3, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Zarnick Jr. MD 15 West 7th St. Frederick, MD 21701

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01670

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Frances Vandall				2. Date of Death Month Day Year January 4, 2004		3. Time of Death 8:00 P M	
	4a. Facility Name (If not institution, give street and number) Goodwill Mennonite Home				4b. City, Town, or Location of Death Grantsville		4c. County of Death Garrett	
Funeral Director	5. Social Security Number 171-14-4406	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 11, 1911		9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Garrett	10c. City, Town or Location Friendsville			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number Friendship Heights			10f. Zip Code 21531		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant		16b. Kind of Business/Industry Kitchen Manufacture		
	17. Father's Name (First, Middle, Last) unk unk Jones				18. Mother's Name (First, Middle, Maiden Surname) unk unk Hulings			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Frank J. Vandall/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1787 Stone Cliff Ct., Decatur, Ga. 30633			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Thayerville Cemetery		Date 1/7/2004		20c. Location - City or Town, State Oakland, Maryland	
	21. Signature of Funeral Service Licensee B. A. [Signature]		22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550					
	23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia, Alzheimer's type						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D0025759		29d. Date signed (Month, Day, Year) January 4, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter K. Naumann, M.D., PO Box 247, Accident MD 21520								
31. Date filed (Month, Day, Year) JAN 05 2004		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01671

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Robert W. Vostreys, Jr.

2. Date of Death

January 3, 2004

3. Time of Death

3:00pm

4a. Facility Name (If not institution, give street and number)

Montgomery Village Care and Rehab Center

4b. City, Town, or Location of Death

Montgomery Village Montgomery

4c. County of Death

Montgomery

5. Social Security Number

149-32-6963

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs

Hours Min.

8. Date of Birth

June 11, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19301 Watkins Mill Road

10f. Zip Code

20886

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bio-Chemist

16b. Kind of Business/Industry

Science

17. Father's Name (First, Middle, Last)

Robert W. Vostreys, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marie C. Crowe

19a. Informant's Name/Relationship (Type, Print)

Marlene V. Doub (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Glengarry Lane, Hainesport, NJ 08036

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

1/5/04

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 20877

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Throat Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 51280

29d. Date signed (Month, Day, Year)

January 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anushiravan Dadgar, M.D. 13219 Executive Park Terrace, Germantown, MD 20874

31. Date filed (Month, Day, Year)

JAN 07 2004

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item # 31 &amp; 32, TCHD, 01/08/04, sbb

State of Maryland / Department of Health and Mental Hygiene

2004 01672

Amended, #31 &amp; 32, TCHD, 01/08/04, sbb

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Webster Wright</b>				2. Date of Death Month Day Year <b>January 6, 2004</b>		3. Time of Death <b>2005 M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>214-28-3096</b>		6. Sex <b>152 M 2 F</b>		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11-22-1920</b>	
	9. Birthplace (State or Foreign Country) <b>Queen Anne Co</b>		10a. State <b>MD.</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>Wittman</b>	
10d. Inside City Limits <b>1 X Yes 2 No</b>		10e. Street and Number <b>22581 Pot Pie Road</b>		10f. Zip Code <b>21676</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>1 X Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 X Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 X Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 5 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Saw Mill</b>		17. Father's Name (First, Middle, Last) <b>Daniel Webster Wright</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Annie Legg</b>		19a. Informant's Name/Relationship (Type, Print) <b>Isabelle Fisch (social worker)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 201 Wittman, Md. 21676</b>		20a. Method of Disposition <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Memorial</b>		20c. Location - City or Town, State <b>Easton, MD</b>		21. Signature of Funeral Service Licensee <b>R. Carroll Hurley</b>		22. Name and Address of Facility <b>R. Carroll Hurley Funeral Home, PC. P.O. Box 518, St. Michaels MD. 21663</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>MYOCARDIAL INFARCTION</b>		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. If yes, outcome of pregnancy <b>1 X Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)</b>		23d. Date of delivery Month Day Year		
23e. Did tobacco use contribute to the cause of death? <b>1 X Yes 2 No 3 Probably 4 Unknown</b>		24a. Was an autopsy performed? <b>1 X Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 X Yes 2 No</b>		25. Was case referred to medical examiner? <b>1 X Yes 2 No</b>		
26. Place of Death (Check only one) Hospital: <b>1 X Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>		27. Manner of Death <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day Year) <b>1-7-03</b>		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <b>1 X Yes 2 No</b>		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29b. Signature and title of certifier <b>John Botsis</b>		29c. License number <b>ID0059487</b>		29d. Date signed (Month, Day, Year) <b>1-7-03</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Botsis, MD. 219 S. Washington St. Easton, Md. 21601</b>		31. Date filed (Month, Day, Year) <b>2004</b>		32. Registrar's Signature <b>JAN 08 2004</b>		33. State Registrar		



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01673

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Amy Wriston</i>				2. Date of Death Month <i>JANUARY</i> Day <i>06</i> Year <i>2004</i>				3. Time of Death <i>2111</i> M	
	4a. Facility Name (If not institution, give street and number) <i>Union Hospital</i>				4b. City, Town, or Location of Death <i>Elkton</i>				4c. County of Death <i>Cecil</i>	
Funeral Director	5. Social Security Number <i>221-54-3761</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>45</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Feb 13, 1958</i>		9. Birthplace (State or Foreign Country) <i>DE</i>	
	Usual Residence of Decedent									
10a. State <i>MD</i>		10b. County <i>Cecil</i>		10c. City, Town or Location <i>Elkton</i>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <i>35 South Edgewood Drive</i>				10f. Zip Code <i>21921</i>				10g. Citizen of What Country? <i>USA</i>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i></i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>restaurant manager</i>				16b. Kind of Business/Industry <i>food service</i>		
17. Father's Name (First, Middle, Last) <i>John Wriston</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Tam Vosburgh</i>						
19a. Informant's Name/Relationship (Type, Print) <i>John Wriston/father</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>13 Amherst Drive, Newark, DE 19711</i>						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>R.T. Foard Funeral Home P.A.</i>		Date <i>01/09/2004</i>		20c. Location - City or Town, State <i>Rising Sun, MD</i>		
21. Signature of Funeral Service Licensee <i>Frank C. McAllister</i>				22. Name and Address of Facility <i>R.T. Foard &amp; Jones 122 West Main St., Newark, DE 19711</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>CARDIORESPIRATORY ARREST</i> Due to (or as a consequence of): b. <i>PULMONARY EMBOLUS</i> Due to (or as a consequence of): c. <i></i> Due to (or as a consequence of): d. <i></i> Approximate Interval Between Onset and Death <i>immediate</i> <i>hours</i>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature] MD</i>				29c. License number <i>00059640</i>				29d. Date signed (Month, Day, Year) <i>JANUARY 06, 2004</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Michael Breyer, MD 166 Bow Street Elkton, MD</i>										
31. Date filed (Month, Day, Year) <i>JAN 09 2004</i>				32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 905a.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01674

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

VIRGINIA RAE WEBSTER

2. Date of Death

Month Day Year  
JANUARY 3, 2004

3. Time of Death

4:30 p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

309 Calvin Drive

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

214-36-5608

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 28, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

309 Calvin Drive

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Food Service

16b. Kind of Business/Industry

Board of Education

17. Father's Name (First, Middle, Last)

Victor D. Abbott

18. Mother's Name (First, Middle, Maiden Surname)

Hattie F. Sterling

19a. Informant's Name/Relationship (Type, Print)

Christopher E. Webster/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

613 Clyde Ave., Fruitland, MD 21826

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Springhill Memory Gardens

Date

1/7/04

20c. Location - City or Town, State

Hebron, MD

21. Signature of Funeral Service Licensee

*Michael J. Dean*

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 2180423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Metastatic Uterine Ca*

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 mo

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Joseph V. Grasso*

29c. License number

D 20705

29d. Date signed (Month, Day, Year)

1/5/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph V. Grasso 145 E. CARROLL ST SALISBURY MD

31. Date filed (Month, Day, Year)

JAN 06 2004

32. Registrar's Signature

*Sparks*

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #24aper VERRALG8282/25/04 Certificate of Death

Reg. No. 2004 01675

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Karlton Tyrme Wilson</b>				2. Date of Death Month <b>January</b> Day <b>3</b> Year <b>2004</b>				3. Time of Death <b>4:00AM</b>					
	4a. Facility Name (If not institution, give street and number) <b>22 Parole Street</b>				4b. City, Town, or Location of Death <b>Annapolis</b>				4c. County of Death <b>Anne Arundel</b>					
Funeral Director	5. Social Security Number <b>212-76-3900</b>				6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>43</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 11, 1960</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number <b>22 Parole Street</b>				10f. Zip Code <b>21401</b>				10g. Citizen of What Country? <b>United States of America</b>					
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>				16b. Kind of Business/Industry <b>State Government</b>					
	17. Father's Name (First, Middle, Last) <b>Calvin Wilson</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Bernice Larkins</b>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Shonnette Blake/neice</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1637 Elkwood Ct. Annapolis, MD 21401</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakemont</b>				20c. Location - City or Town, State <b>Jan. 9, 2004 Davidsonville, MD</b>					
	21. Signature of Funeral Service Licensee <b>Jeffrey Miller</b>				22. Name and Address of Facility <b>Miller's Metropolitan Chapel 1922 First Dr. Annapolis, MD</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Adult immunodeficiency syndrome</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):													
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown													
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown													
	23d. Date of delivery Month Day Year													
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	29b. Signature and title of certifier <b>Peter R. Grare MD</b>				29c. License number <b>D16364</b>				29d. Date signed (Month, Day, Year) <b>01/05/04</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peter R. Grare MD 908 Westbaders #300 Annapolis MD 21401</b>														
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>				32. Registrar's Signature <b>Ken B. Ford</b>										

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
A.A. 24A  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #24aper VERBAL 68282/25/04 Certificate of Death

Reg. No.

2004 01676

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gladys Davis Wieber</b>				2. Date of Death Month Day Year <b>JANUARY 03 2004</b>		3. Time of Death <b>1330 M</b>	
	4a. Facility Name (If not institution, give street and number) <b>THE MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>	
Funeral Director	5. Social Security Number <b>496-26-0980</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 19, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>Alabama</b>		10a. State <b>Maryland</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Goldsboro</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>15329 Church Ln</b>		10f. Zip Code <b>21636</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>				
17. Father's Name (First, Middle, Last) <b>John Louis Davis</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Mae (unknown)</b>		19a. Informant's Name/Relationship (Type, Print) <b>Candy Cook daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15329 Church LN Goldsboro, MD 21636</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greensboro Cemetery</b>		20c. Date <b>01/07/2004</b>		20d. Location - City or Town, State <b>Greensboro, MD</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Fleegle and Helfenbein Funeral Home PA</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>sepsis</b> Due to (or as a consequence of): <b>pneumonia</b> Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Rapid Atrial Fibrillation</b> <b>dehydration</b>		Approximate Interval Between Onset and Death		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Rapid Atrial Fibrillation</b> <b>dehydration</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Haiou Laura Jin</b>		29c. License number <b>D55484</b>		
29d. Date signed (Month, Day, Year) <b>1/5/04</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Haiou Laura Jin 219 S. Washington St Easton, Maryland 21601</b>		31. Date filed (Month, Day, Year) <b>JAN - 6 2004</b>		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01677

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Louise Katherine Lerch Williams</b>				2. Date of Death Month Day Year <b>January 7, 2004</b>		3. Time of Death <b>8:40 A M</b>		
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>578-03-4008</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 16, 1908</b>		9. Birthplace (State or Foreign Country) <b>Washington DC</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Davidsonville</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>2883 Patuxent River Road</b>				10f. Zip Code <b>21035</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Secretary</b>		16b. Kind of Business/Industry <b>Medical</b>				
	17. Father's Name (First, Middle, Last) <b>John Jacob Bernard Lerch</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Julia Hanft</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Elaine L. Bassford/niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1152 Doublegate Road Davidsonville, MD 21035</b>				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Crematory</b>		Date <b>1/8/2004</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		
	21. Signature of Funeral Service Provider <i>Donald S. Taylor</i>				22. Name and Address of Facility <b>John M. Taylor Funeral Home 147 Duke of Gloucester Annapolis, MD 21401</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CUA</b>								
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown									
23d. Date of delivery Month Day Year									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>Stanley A. Watkins</i>				29c. License number <b>D08118</b>		29d. Date signed (Month, Day, Year) <b>January 7, 2004</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STANLEY A. WATKINS JR 900 BISTOLATE RD ANNAPOLIS MD 21401</b>									
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature <i>Don S. Taylor</i>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01678

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jean Virginia Webber

2. Date of Death

January 1, 2004

3. Time of Death

4:35P M

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

230-20-7903

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

8. Date of Birth

Sept. 5, 1906

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1498 Key Parkway

10f. Zip Code

21702

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

William

Young

18. Mother's Name (First, Middle, Maiden Surname)

Isabella

Hutchinson

19a. Informant's Name/Relationship (Type, Print)

Carol Jean Webber/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1498 Key Parkway, Frederick, MD 21702

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Frederick Crematory

Date

1/5/2004

20c. Location - City or Town, State

Frederick, MD

21. Signature of Funeral Service Licensee

W. B. Gieser

22. Name and Address of Facility

Stauffer Funeral Home  
1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA, ASPIRATION

Approximate Interval Between Onset and Death

8 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ILEUS

8 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AFRIL FIBRILLATION, PYD, OSTEOPOROSIS,  
SPINAL STENOSIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Donelson MD

29c. License number

D21936

29d. Date signed (Month, Day, Year)

1/2/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DONELSON, MD 65-C Thomas Johnson DR. FREDERICK 21702

State  
Registrar

31. Date filed (Month, Day, Year)

JAN - 6 2004

32. Registrar's Signature

Barbara S. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01679

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elaine E. Warden</b>				2. Date of Death Month <b>JAN.</b> Day <b>6</b> Year <b>2004</b>				3. Time of Death <b>12 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>ST. AGNES HEALTHCARE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death	
Funeral Director	5. Social Security Number <b>577-12-8833</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 19, 1919</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>719 Maiden Choice Lane, HR 513</b>				10f. Zip Code <b>21228-6134</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>				16b. Kind of Business/Industry <b>Self-Employed</b>		
17. Father's Name (First, Middle, Last) <b>William L. Edwards</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes C. Watts</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Elisabeth Cupples/ Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7425 Democracy Blvd., Bethesda, MD 20817</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>January 10 2004</b>		20c. Location - City or Town, State <b>Suitland, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Annetaeig...</i>				22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b> Due to (or as a consequence of): <b>acute myelogenous leukemia</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death <b>2 days</b> <b>2 weeks</b>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>status post Mullan-Barré syndrome 30 years ago with subsequent lower extremity weakness</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Dan...</i>				29c. License number <b>D22114</b>		29d. Date signed (Month, Day, Year) <b>1/6/04</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DANIEL E. BECHTOLD MD 5411 OLD FREDERICK ROAD, SUITE 18, BALTIMORE, MARYLAND 21207</b>										
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>				32. Registrar's Signature <i>...</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01680

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

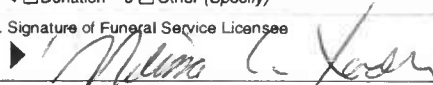
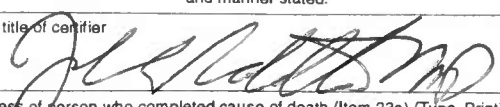
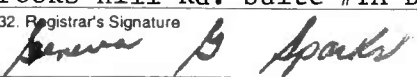
1. Decedent's Name (First, Middle, Last) <b>MORRIS WIESENFELD</b>				2. Date of Death Month Day Year <b>JANUARY 1, 2004</b>		3. Time of Death <b>7:00 P<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>HEBREW HOME OF GREATER WASHINGTON</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>092-09-9085</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>94</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>01/03/1909</b>	
9. Birthplace (State or Foreign Country) <b>NEW YORK</b>							
Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>POTOMAC</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1727 SUNRISE DRIVE</b>				10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/> <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLAIMS EXAMINER</b>		16b. Kind of Business/Industry <b>WORKMAN'S COMPENSATION</b>	
17. Father's Name (First, Middle, Last) <b>CHARLES WIESENFELD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BLUMA LEFKOWITZ</b>			
19a. Informant's Name/Relationship (Type, Print) <b>PAUL R. WIESENFELD/SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1727 SUNRISE DRIVE, POTOMAC, MD 20854</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NATIONAL CREMATORY</b>		Date <b>01/05/2004</b>		20c. Location - City or Town, State <b>FALLS CHURCH, VIRGINIA</b>	
21. Signature of Funeral Service Licensee <b>Donald C. Stettin</b>				22. Name and Address of Facility <b>EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Myocardial infarction</b>				Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check on <u>one</u> Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Gregory A. Compton MD</b>		29c. License number <b>D24942</b>	
29d. Date signed (Month, Day, Year) <b>JAN 01, 2004</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GREGORY A - COMPTON MD 6121 Montrose Rd Rockville</b>							
31. Date filed (Month, Day, Year) <b>JAN 07 2004</b>				32. Registrar's Signature <b>Benita S Sparks</b>			

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For MEND#10e for INF1/13/04, BW, Moco  
State Registrar MEND#10e MDI/1304, BW, Moco  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2004 01681

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALICE MCFARLAND WILSON</b>		2. Date of Death Month <b>January</b> Day <b>04</b> Year <b>2004</b>		3. Time of Death <b>5:45 P M</b>
	4a. Facility Name (If not institution, give street and number) <b>Carriage Hill Nursing Home</b>		4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>579-07-5119</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 18, 1915</b>
	9. Birthplace (State or Foreign Country) <b>Texas</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Bethesda</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>5225 Pooks Hill Road, Apt. 130</b>		10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>4+</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Arthur McFarland</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Williamson</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Margo London / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5112 Nahant St., Bethesda, MD 20816</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Comfort Crematory</b>		20c. Location - City or Town, State <b>Jan. 7, 2004 Alexandria, Virginia</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, DC 20016</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Bladder Cancer</b>				Approximate Interval Between Onset and Death <b>3 Months</b>
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>			
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D0011921</b>		29d. Date signed (Month, Day, Year) <b>January 6, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. John Galotto 5225 Pooks Hill Rd. Suite #1A Bethesda MD 20814</b>					
31. Date filed (Month, Day, Year) <b>JAN 08 2004</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01682

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth J. Wolfe, Jr.

2. Date of Death  
Month Day Year

January 5, 2004

3. Time of Death

12:20 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

213-38-2039

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Oct 11, 1940

9. Birthplace (State or Foreign  
Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland Prince Georges

10b. County

Adelphi

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9118 Riggs Rd

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1957-  
196113. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Stage Hand

16b. Kind of Business/Industry

Theatre

17. Father's Name (First, Middle, Last)

Kenneth J. Wolfe, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Hoopes

19a. Informant's Name/Relationship (Type, Print)

Frances R. Wolfe/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9118 Riggs Rd, Adelphi, MD 20783

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Crematory Jan 8, 2004 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Alan J. Donnell

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Ave, Silver Spring, MD 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Hepatic Failure

Due to (or as a consequence of):

b. cirrhosis of liver

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Several months

Several years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

MKam MD

29c. License number

D-18895

29d. Date signed (Month, Day, Year)

January 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MD 20912

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 08 2004

32. Registrar's Signature

Benita B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01683

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Joseph Young

2. Date of Death

Month Day Year  
Jan. 4, 2004

3. Time of Death

7:30 p M

4a. Facility Name (If not institution, give street and number)

654 Bay Green Drive

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

366-16-7456

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 22, 1919

9. Birthplace (State or Foreign Country)

MI

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

654 Bay Green Drive

10f. Zip Code

21012

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII  
Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

US Navy

16b. Kind of Business/Industry

Military

17. Father's Name (First, Middle, Last)

Frank Joseph Young

18. Mother's Name (First, Middle, Maiden Sumame)

Pearl Edna Myers Farrington

19a. Informant's Name/Relationship (Type, Print)

Madeline R. Young/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

654 Bay Green Drive, Arnold, MD 21012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National

Date

Jan. 21,  
2004

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy, Severna Park, MD 2114623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

b. Sarcoidosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Non insulin dependent diabetes

- severe GERD / colitis

- severe osteoporosis 20 to long term steroids

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D40781

29d. Date signed (Month, Day, Year)

1/9/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Catherine Jane Haslam

Naval Academy Clinic  
Annapolis MD 21401

31. Date filed (Month, Day, Year)

JAN 12 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01684

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Link Andrae			2. Date of Death Month Day Year January 19, 2004		3. Time of Death 2:00 p M	
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital			4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-34-6095	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 5, 1908	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Howard	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 5930 Setter Drive		10f. Zip Code 21075		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Fredrick William Andrae			18. Mother's Name (First, Middle, Maiden Surname) Ida F. Apple			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Charles W. Andrae Jr. (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5930 Setter Dr., Baltimore, MD 21075			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematorium, or place) Baltimore Crematory @ Loudon Park		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Aspiration pneumonia</u> Due to (or as a consequence of): b. <u>Malnutrition; Cachexia</u> Due to (or as a consequence of): c. <u>Renal failure</u> Due to (or as a consequence of): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Malnutrition; Cachexia</u> <u>Renal failure</u>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <u>D. Salyard</u>		29c. License number D 17537		29d. Date signed (Month, Day, Year) 1-19-04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DARSHAN S. SALYARD MD 1600 W. MOUNT ROYAL AVE. BALTO 21217							
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature <u>Sparks</u>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01685

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWARD BURNS</b>		2. Date of Death Month <b>JANUARY</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>3:42 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL 5601 LOCK RAVEN BOULEVARD</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE CITY</b>
Funeral Director	5. Social Security Number <b>216-03-2837</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Sep 11, 1913</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>Baltimore</b>
	10c. City, Town or Location <b>Parkville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3117 Dubois Avenue</b>		10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Baker</b>
	16b. Kind of Business/Industry <b>Bakery</b>		17. Father's Name (First, Middle, Last) <b>Thomas E. Burns</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Fritz</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Ms. Margaret Sue Burns/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3117 Dubois Avenue, Parkville, MD 21234</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>Jan 22 2004</b>
	20c. Location - City or Town, State <b>Beltsville, MD</b>		21. Signature of Funeral Service Licensee <b>[Signature] M00986</b>		22. Name and Address of Facility <b>Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD</b>
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>PROBABLE MYOCARDIAL INFARCTION</b>				
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>23c. If yes, outcome of pregnancy</b> <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>[Signature] MD</b>					
29c. License number <b>D30950</b>					
29d. Date signed (Month, Day, Year) <b>JANUARY 20, 2004</b>					
30. Name and address of person who completed cause of death (Item 22a) (Type, Print) <b>EDWARD BURNS 5601 LOCK RAVEN BOULEVARD BALTIMORE MARYLAND 21234</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>					
32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01686

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Mattie Bell Davis Booker</b>			2. Date of Death Month <b>JANUARY</b> Day <b>17</b> Year <b>2004</b>		3. Time of Death <b>0949 A M</b>
4a. Facility Name (If not institution, give street and number) <b>700 W. LEXINGTON STREET</b>			4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death
5. Social Security Number <b>249-76-2892</b>	6. Sex <b>1 M</b> <del>2 F</del>	7. Age (In yrs. last birthday) <b>58</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>04 01 45</b>		9. Birthplace (State or Foreign Country) <b>SC</b>
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <b>1 X</b> Yes <b>2</b> No
10e. Street and Number <b>5016 Carmine Drive</b>			10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4 X</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2 X</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2 X</b> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th grade</b> College (1-4 or 5+) <b>na</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>House Keeper</b>		16b. Kind of Business/Industry <b>Hospital</b>			
17. Father's Name (First, Middle, Last) <b>Nathaniel Davis</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Karen Evans</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Annette Davis-Jackson Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11103 Worchester Drive, New Market, Md 21774</b>		
20a. Method of Disposition <b>1 X</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. Location - City or Town, State <b>1/24/04 Baltimore Co, Md</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore Md 21215</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Intracranial Hemorrhage</b> <b>b. Hypertensive Cardiovascular Disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1</b> Yes <b>2 X</b> No <b>9</b> Unknown		23c. If yes, outcome of pregnancy <b>1</b> Live birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy <b>4</b> Pregnant at time of death <b>5</b> Other (specify) <b>9</b> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2 X</b> No <b>3</b> Probably <b>4</b> Unknown	
24a. Was an autopsy performed? <b>1 X</b> Yes <b>2</b> No				24b. Were autopsy findings available prior to completion of cause of death? <b>1 X</b> Yes <b>2</b> No	
25. Was case referred to medical examiner? <b>1 X</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6 X</b> Other (Specify) <b>AT SCENE</b>			
27. Manner of Death <b>1 X</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2 X</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 18, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01687

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Battle, Jr</b>		2. Date of Death Month <b>1</b> Day <b>19</b> Year <b>2004</b>		3. Time of Death <b>11:00 a.M</b>
	4a. Facility Name (If not institution, give street and number) <b>2200 Tucker Lane Apt 2 C</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>215-34-9451</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>3-7-1938</b>	
	9. Birthplace (State or Foreign Country) <b>Ga</b>		Usual Residence of Decedent		
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>2200 Tucker Lane Apt 2C</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>na</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Staff Sergeant</b>		16b. Kind of Business/Industry <b>U.S. Army</b>		
	17. Father's Name (First, Middle, Last) <b>James Battle Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Eloise Brown</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Janis Battle-Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6184 Majors Lane, Columbia, Md 21045</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. 1/23/04 Owings Mills, Md</b>		
	21. Signature of Funeral Service Licensee <b>Leanne A. Thompson</b>		22. Name and Address of Facility <b>March F/H West 4300 Wabash Avenue Balto, Md 21215</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Ischemic Cardiomyopathy</b> <b>b. Diabetes mellitus</b> <b>c. Hypertension</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Disease</b> <b>End Stage Renal Disease</b>					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
26. Place of Death (Check only one) 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier <b>Dr. [Signature]</b> 29c. License number <b>D35069</b> 29d. Date signed (Month, Day, Year) <b>1-21-04</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>3100 Wyman Park Drive Baltimore MD 21211</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b> 32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perennial. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Amend Item #23a, pt. II, 27, 28a-f per me G828 2/5/04  
1- For State Registrar

Certificate of Death

Reg. No.

2004 01688

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
DirectorPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>JOHN MICHAEL BEASLEY</b>		2. Date of Death Month Day Year <b>January 10, 2004</b>		3. Time of Death <b>1110 A.<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>827 - 50th Street</b>		4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>212-78-2853</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>41</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>8/6/1961</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			
10a. State <b>NJ</b>		10b. County <b>MONMOUTH</b>		10c. City, Town or Location <b>MANALAPAN</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>139 OAKLAND MILLS ROAD</b>		10f. Zip Code <b>07726</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ELECTRICIAN</b>		16b. Kind of Business/Industry <b>ELECTRICAL</b>		17. Father's Name (First, Middle, Last) <b>BRUCE BEASLEY</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>BARBARA SUMLIN</b>		19a. Informant's Name/Relationship (Type, Print) <b>BONNIE L. HALKA</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>60 STILLHOUSE ROAD, ENGLISHTOWN, NJ 07726</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. JOSEPH CEMETERY</b>		20c. Date <b>1/15/2004</b>	
20d. Location - City or Town, State <b>MILLSTONE TOWNSHIP, NJ</b>		21. Signature of Funeral Service Licensee <b>KELLY GREGORY FINK #MO1148</b>		22. Name and Address of Facility <b>FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiomegaly complicated by Narcotic Intoxication</b> Due to (or as a consequence of): <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>At scene</b>	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>Found 1/10/04</b>		28b. Time of Injury <b>Found at 11:00 a</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Unknown</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Found in house</b>	
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>827 50th St. Baltimore County, Md</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Patricia Aronica Poliak</b>	
29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>January 11, 2004</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PATRICIA ARONICA POLIAK MD 111 Penn Street, Baltimore, Maryland 21201</b>	
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01689

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

OREE

BLACK

2. Date of Death

Month

Day

Year

JANUARY 21 2004

3. Time of Death

5:49A M

4a. Facility Name (If not institution, give street and number)

BON Secours Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

213-30-5111

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

September 3, 1932

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

837 N. Bentalow Street

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Laundry

17. Father's Name (First, Middle, Last)

Moses Hicks

18. Mother's Name (First, Middle, Maiden Surname)

Oriolee Hicks

19a. Informant's Name/Relationship (Type, Print)

Karen D. Black-Wooden Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

837 N. Bentalow Street Baltimore, MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Mt Tarry 27, 2004

Date

20c. Location - City or Town, State

Dwightville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Wylie Funeral Home PA

638 N. Gilson Street

21217

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Diabetes mellitus

Due to (or as a consequence of):

d. Stroke

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician

29b. Signature and title of certifier

[Signature] PHYSICIAN

29c. License number

D 57543

29d. Date signed (Month, Day, Year)

1-21-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. SANDHU, MD, 700 WASHINGTON BLVD, BALTIMORE, MD 21230

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2004 01690

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Martha

Barnette

2. Date of Death

January 16 2004

3. Time of Death

1751 M

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

214 30 6819

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 15, 1927

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1400 2 Madison Street

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Nurses And

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Jerry Halsey

18. Mother's Name (First, Middle, Maiden Surname)

Martha Halsey

19a. Informant's Name/Relationship (Type, Print)

Betty Faulken

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1030 Cay Apt 545 Gen Burns MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

King Memorial Park

Date

1/23/03

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Betty Faulken

22. Name and Address of Facility

Bells Funeral Home  
1109 N. Caroline St Baltimore MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

b. Respiratory failure

Due to (or as a consequence of):

c. coronary heart disease

Due to (or as a consequence of):

d. Chronic Obstructive Lung disease

Approximate Interval Between Onset and Death

1 day

1 day

5 years

5 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier.

Cynthia DeRuiter

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia DeRuiter, The Johns Hopkins Hospital, 600 N. Wolfe Street, Baltimore, Maryland 21205

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01691

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marie Henrietta Bruner</b>				2. Date of Death Month Day Year <b>January 17, 2004</b>		3. Time of Death <b>11:05 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Wilson Health Care Center</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>705-05-2867</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>102</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 15, 1901</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>407 Russell Avenue</b>				10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>secretary</b>		16b. Kind of Business/Industry <b>B&amp;O railroad</b>	
	17. Father's Name (First, Middle, Last) <b>Simon Assen Bruner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Henrietta Berghammer</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Helen Turowski/cousin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2419 Cider Mill Road Baltimore, MD 21234</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. pneumonia</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ischemic heart disease</b> <b>atrial fibrillation</b> <b>cerebrovascular disease</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D19294</b>		29d. Date signed (Month, Day, Year) <b>January 17, 2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John R. Melnick 911 Russell Ave. Gaithersburg, Md. 20879</b>								
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01692

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

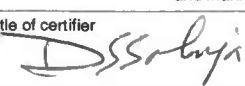
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>AGNES LEE BROWN</b>				2. Date of Death Month Day Year <b>JANUARY 21, 2004</b>				3. Time of Death <b>11:25am</b>										
4a. Facility Name (If not institution, give street and number) <b>FUTURE CARE SANDTOWN</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>										
5. Social Security Number <b>066-16-0213</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>12-23-1913</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>										
Usual Residence of Decedent																		
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number <b>3709 DORCHESTER RD.</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>												
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-12-</b> College (1-4 or 5+) <b>-0-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>			16b. Kind of Business/Industry <b>GOVERNMENT</b>											
17. Father's Name (First, Middle, Last) <b>JOSEPH LEE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>AGNES PENNINGTON</b>														
19a. Informant's Name/Relationship (Type, Print) <b>DELORES BISHOP(NIECE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3228 DORITHAN RD. BALTIMORE, MARYLAND 21215</b>														
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK</b>		Date <b>1-28-2004</b>		20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>												
21. Signature of Funeral Service Licensee 		Name and Address of Facility <b>PHILLIPS FUNERAL HOME, P.A.</b>		1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4">           Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Atherosclerotic Cardiovascular Disease</b></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Hypertension</b></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>										Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Atherosclerotic Cardiovascular Disease</b>	Due to (or as a consequence of):	b. <b>Hypertension</b>	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):
Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Atherosclerotic Cardiovascular Disease</b>	Due to (or as a consequence of):																
	b. <b>Hypertension</b>	Due to (or as a consequence of):																
	c.	Due to (or as a consequence of):																
	d.	Due to (or as a consequence of):																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																		
<table border="0"> <tr> <td>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>017537</b>		29d. Date signed (Month, Day, Year) <b>1-22-04</b>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DARSHAN S. SALUJA 1600 W. MOUNT Royal Ave, Baltimore MD 21217</b>																		
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 																



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01693

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Norman F. Connelly</b>				2. Date of Death Month <b>Jan</b> Day <b>20</b> Year <b>2004</b>				3. Time of Death <b>7:20</b> P M		
	4a. Facility Name (If not institution, give street and number) <b>Gilchrest Center</b>				4b. City, Town, or Location of Death <b>Towson</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>216-30-7250</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 25 1935</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>5 Brett Court</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Guard</b>			16b. Kind of Business/Industry <b>Security</b>			
	17. Father's Name (First, Middle, Last) <b>William J. Connelly Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine E. Higgs</b>						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Bruchey/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14 E. Starwood Court Baltimore MD</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley</b>		Date <b>1/24/04</b>		20c. Location - City or Town, State <b>Baltimore MD</b>				
	21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>				22. Name and Address of Facility <b>Connelly Funeral Home of Essex</b> <b>300 Mace Ave. Baltimore MD 21221</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>recurrent Aspiration pneumonia</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Dysphagia, due To debility and remote History of prior neck surgery for Cancer</b>				Approximate Interval Between Onset and Death <b>weeks</b> <b>weeks</b>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>obstructive lung disease</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Dr. Anthony Miley, MD</b>				29c. License number <b>025205</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 21, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A.R. Ley G.M.C. 6701 N. Charles St. Balto. md 21204</b>				31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>				32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01694

Certificate of Death

Reg. No.

1- For State Registrar

Physician / Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Eugene Denard Callaway, Sr.				2. Date of Death Month 1 Day 19 Year 04		3. Time of Death 9 AM	
4a. Facility Name (If not institution, give street and number) 171 Chapeltowne Circle				4b. City, Town, or Location of Death Perry Hall		4c. County of Death Baltimore	
5. Social Security Number 218-36-9948		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) July 31, 1940	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Perry Hall		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 171 Chapeltowne Circle				10f. Zip Code 21236		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouseman		16b. Kind of Business/Industry B. Greene & Company	
17. Father's Name (First, Middle, Last) George Callaway				18. Mother's Name (First, Middle, Maiden Surname) Madeline Baumgartner			
19a. Informant's Name/Relationship (Type, Print) Eugene Callaway, Jr. (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1112 W. 38th Street Baltimore, MD 21211			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington Crematory		Date 01/24/2004		20c. Location - City or Town, State Laurel, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Furgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cancer Lung</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>Daughter's Residence</u>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D23076		29d. Date signed (Month, Day, Year) 1/19/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. Dwyer 3730 Falls Rd Balt Md 21211							
31. Date filed (Month, Day, Year) JAN 23 2004				32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01695

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Doris F. Cook</b>				2. Date of Death Month <b>January</b> Day <b>19<sup>th</sup></b> Year <b>2004</b>		3. Time of Death <b>1:55 aM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>218-28-1450</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 28, 1932</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>404 Scarsdale Road</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>Waitress</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Resteraunt</b>		
17. Father's Name (First, Middle, Last) <b>Jerome S. Machovec</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Florence E. Smith</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Linda Hess / daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>344 Townsend Road Baltimore MD 21221</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		Date <b>1/22/04</b>		20c. Location - City or Town, State <b>Baltimore MD</b>	
21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>					22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 M Ace Ave. Baltimore MD 21221</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Gastrointestinal Bleed</b> Due to (or as a consequence of): <b>Colon Cancer</b> Due to (or as a consequence of): <b>4 years</b>								
Approximate Interval Between Onset and Death <b>2-3 hours</b>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Dr. David Farnie</b>					29c. License number <b>P214668</b>		29d. Date signed (Month, Day, Year) <b>1/19/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. David Farnie 9000 Franklin Square Drive Baltimore, MD. 21237</b>								
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>			32. Registrar's Signature <b>[Signature]</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01696

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Anthony Kingsley Ceasar

2. Date of Death  
Month Day Year

January 21 04

3. Time of Death

7:15a. M

4a. Facility Name (If not institution, give street and number)

4 Mill Point Court

4b. City, Town, or Location of Death

Owings Mills

4c. County of Death

Baltimore

5. Social Security Number

213-92-7778

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

02 05 62

9. Birthplace (State or Foreign Country)

Trinidad

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 Mill Point Court

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

na

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Auto Technician

16b. Kind of Business/Industry

Auto Shop

17. Father's Name (First, Middle, Last)

Conrad Wickham

18. Mother's Name (First, Middle, Maiden Surname)

Albertine Ceasar

19a. Informant's Name/Relationship (Type, Print)

Melanie Ceasar-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Mill Point Court, Owings Mills Md 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King Memorial Park 1/26/04 Randallstown, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gloria A. Thompson

22. Name and Address of Facility

March F/H West  
4300 Wabash Ave, Baltimore Md 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC GASTRIC CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE CANCER PAIN, on DILAUDID  
ORAP

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Shirley Thompson-Richards

29c. License number

D0033215

29d. Date signed (Month, Day, Year)

1/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Shirley Thompson-Richards, M.D., 7401 Osler Drive, Towson MD 21204

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

K. A. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-358-9058.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01697

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Donald Riordan Christ

2. Date of Death

JANUARY 19, 2004

3. Time of Death

8:13 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

203-24-3332

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

8. Date of Birth (Month, Day, Year)

12/07/1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1803 Sherry Hill Court

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanical Engineer

16b. Kind of Business/Industry

Bethlehem Steel Corp.

17. Father's Name (First, Middle, Last)

Herbert William Christ

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Ann Riordan

19a. Informant's Name/Relationship (Type, Print)

Rita M. Christ (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1803 Sherry Hill Court - Fallston, MD 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highview Mem. Gardens 01/23/2004 Fallston, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E. F. Lassahn Funeral Home, P.A.  
11750 Belair Road - Kingsville, MD 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. UPPER GASTROINTESTINAL BLEED

Due to (or as a consequence of):

b. ESOPHAGEAL VARICES

Due to (or as a consequence of):

c. LIVER METASTASES

Due to (or as a consequence of):

d. TRANSITIONAL CELL CANCER OF BLADDER

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Timothy Low, M.D.

29c. License number

D 24034

29d. Date signed (Month, Day, Year)

1/19/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMOTHY LOW, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01698

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dolores A. Cedar		2. Date of Death Month Day Year January 16, 2004		3. Time of Death 12:04 A <sup>M</sup>
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges
Funeral Director	5. Social Security Number 577-42-9864	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth (Month, Day, Year) June 28, 1930	9. Birthplace (State or Foreign Country) Washington, D.C.
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince Georges	10c. City, Town or Location Forest Heights		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 5806 Blackhawk Drive		10f. Zip Code 20745		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry At Home		
	17. Father's Name (First, Middle, Last) Maurice O'Connor		18. Mother's Name (First, Middle, Maiden Surname) Margaret Cecil		
	19a. Informant's Name/Relationship (Type, Print) Herbert E. Cedar / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5806 Blackhawk Dr., Forest Heights, MD 20745		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cemetery		20c. Location - City or Town, State Suitland, MD
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute myocardial infarction</i> Due to (or as a consequence of): b. <i>S.A.M.I.</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 48 hrs 48 hrs				
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus</i> <i>Hypertension</i>					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i> 29c. License number D35656 29d. Date signed (Month, Day, Year) 1-16-04					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARL SALMANOVIC - 5801 ALLENTOWN RD #500 CAMP SPRING - MD 20746					
31. Date filed (Month, Day, Year) JAN 23 2004 32. Registrar's Signature <i>[Signature]</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 01699

1- For  
State  
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Louise Cook</b>		2. Date of Death Month Day Year <b>January 20, 2004</b>		3. Time of Death <b>1:45 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>327-05-7889</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months Days <b>0 0</b>	If Under 24 Hrs. Hours Min. <b>0 0</b>
	8. Date of Birth (Month, Day, Year) <b>Aug. 10, 1908</b>		9. Birthplace (State or Foreign Country) <b>Illinois</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Catonsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>715 Maiden Choice Lane</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>YMCA</b>		
	17. Father's Name (First, Middle, Last) <b>Philip Carter</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel Irene Snyder</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mary K. Niebuhr (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>128 Kentucky Ave. S.E., Washington, D.C. 20003</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>		20c. Location - City or Town, State <b>Dulaney Valley, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Hypertensive atherosclerotic cardiovascular disease</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)
	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>January 20, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LING LI, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01700

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CURTIS IVANHOE CAVANAUGH

2. Date of Death

JANUARY 20 2004

3. Time of Death

1320

4a. Facility Name (If not institution, give street and number)

MERCY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-24-2127

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 29, 1931

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND N/A

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

XX Yes 20 No

10e. Street and Number

301 McMECHEN STREET

10f. Zip Code

21217

10g. Citizen of What Country?

UNITED STATES OF AMERICA

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 20 No 1952-  
If Yes, Give Year or Dates: 1960

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LONG SHOREMEN

16b. Kind of Business/Industry

SHIPPING

17. Father's Name (First, Middle, Last)

ROSERVELT CAVANAUGH

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA RANDOLPH

19a. Informant's Name/Relationship (Type, Print)

HATTIE L. JOHNSON (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4010 WEST FRANKLIN STREET; BALTIMORE, MARYLAND 21229

20a. Method of Disposition

XX Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

JAN. 26, 2004

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

LOUDON PARK FUNERAL HOME  
3620 WILKINS AVENUE  
BALTIMORE, MARYLAND 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

lung cancer

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

Other:

40 Nursing Home 50 Residence 60 Other (Specify) Hospice

27. Manner of Death

10 Natural 50 Pending investigation  
20 Accident 60 Could not be determined  
30 Suicide  
40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D40854

29d. Date signed (Month, Day, Year)

1/20/2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David, Riseberg 301 ST PAUL PL. Baltimore 21202

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

*[Signature]*

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01701

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THELMA TYNES CAREY

2. Date of Death

Jan 20 2004

3. Time of Death

9:47P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

LEVINDALE GERIATRIC HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-34-8180

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 12, 1935

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

M.D.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4038 Fairfax Road

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Youth Supervisor

16b. Kind of Business/Industry

Department of  
Juvenile Services

17. Father's Name (First, Middle, Last)

Augustus Hamilton Crooms

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Whetstone

19a. Informant's Name/Relationship (Type, Print)

Malcolm Tynes - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4038 Fairfax Rd. Baltimore, M.D. 21216

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Woodlawn Cemetery 1/26/04

Date

20c. Location - City or Town, State

Balto., M.D.

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Home Inc.  
2501 Gwynnsfalls Pkwy Balto., M.D. 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. multi-Infarct Dementia

Due to (or as a consequence of):

b. Cerebral Vascular Accident

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Dysphagia

Peripheral Vascular Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Herbert E. Nutter

29c. License number

056508

29d. Date signed (Month, Day, Year)

Jan 21, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 W Belvedere Ave Baltimore, MD

XIANGRONG SHAO

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

James A. Sparks

State  
Registrar

Baltimore, Maryland 21201-0036

Division of Vital Records P.O. Box 68760, THELMA CAREY

CAREY

CAREY

CAREY

CAREY

CAREY

CAREY

CAREY

CAREY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01702

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>William Chestnut</b>		2. Date of Death Month <b>January</b> Day <b>18</b> Year <b>2004</b>		3. Time of Death <b>2:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Union Mem. hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
5. Social Security Number <b>247-46-5844</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>2-10-31</b>		9. Birthplace (State or Foreign Country) <b>S.C.</b>			
Usual Residence of Decedent					
10a. State <b>Md.</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>1911 29th Street</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th grade</b> College (1-4or 5+) <b>Chauffer</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chauffer</b>		16b. Kind of Business/Industry <b>F P Winner LTD</b>	
17. Father's Name (First, Middle, Last) <b>Willie Chestnut</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie Best</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Marlene Chestnut Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1911 E. 29th Street, Baltimore, Md. 21218</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk.</b>		20c. Location - City or Town, State <b>1-24-04 Arbutus, Md.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Md. 21202</b> <b>March F.H. East 1101 E. North Ave.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial infarction</b> Due to (or as a consequence of): <b>b. Sepsis</b> Due to (or as a consequence of): <b>c. Acute Renal failure</b> Due to (or as a consequence of): <b>d.</b>					
Approximate Interval Between Onset and Death <b>2 minutes</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis</b> <b>Acute Renal failure</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Veronica Epstein M.D.</b>		29c. License number <b>AT 2438946</b>		29d. Date signed (Month, Day, Year) <b>Jan 18, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Veronica Epstein M.D. Union Memorial Hospital Baltimore, MD</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01703

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <u>Selma Carlos</u>		2. Date of Death Month <u>January</u> Day <u>19</u> Year <u>2004</u>		3. Time of Death <u>6:10</u> M	
4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Bayview Care Center</u>		4b. City, Town, or Location of Death <u>Baltimore, Maryland</u>		4c. County of Death <u>Baltimore City</u>	
5. Social Security Number <u>230 209677</u>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>93</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>11-1-10</u>		9. Birthplace (State or Foreign Country) <u>S.C.</u>
Usual Residence of Decedent					
10a. State <u>MD.</u>	10b. County <u>NA</u>	10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <u>4016 Southern Ave.</u>		10f. Zip Code <u>21206</u>		10g. Citizen of What Country? <u>USA</u>	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6th grade</u> College (1-4 or 5+) <u></u>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Factory Worker</u>		16b. Kind of Business/Industry <u>Food Packing Co.</u>			
17. Father's Name (First, Middle, Last) <u>James Carlos</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Maggie Carlos</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Saretha Rawling Daughter</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4016 Southern Ave., Baltimore, Md. 21206</u>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Mt. Zion Cem.</u>		20c. Location - City or Town, State <u>1-24-04 Lansdowne, Md.</u>	
21. Signature of Funeral Service Licensee <u>Joseph S. Walters Jr</u>		22. Name and Address of Facility <u>Baltimore, Md. 21202</u> <u>March F.H. East 1101 E. North Ave.</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Sepsis</u> Due to (or as a consequence of): a. <u>Pressure ulcers - heels</u> Due to (or as a consequence of): b. <u></u> Due to (or as a consequence of): c. <u></u> Due to (or as a consequence of): d. <u></u>					Approximate Interval Between Onset and Death <u>1 week</u>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month <u></u> Day <u></u> Year <u></u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u> <u>Diabetes</u> <u>Malnutrition</u>					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <u></u>		28b. Time of Injury <u>M</u>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred <u></u>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u></u>	
28f. Location (Street and Number or Rural Route Number, City or Town, State) <u></u>		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <u>Michael A. Ankrum MD</u>		29c. License number <u>D46360</u>		29d. Date signed (Month, Day, Year) <u>January 19, 2004</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>MICHAEL A. ANKRUM MD 5505 HOPKINS BAYVIEW CIRCLE</u>					
31. Date filed (Month, Day, Year) <u>JAN 23 2004</u>		32. Registrar's Signature <u></u>			

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01704

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH E. CHAMBERS

2. Date of Death

01 28 04

3. Time of Death

17:09M

4a. Facility Name (If not institution, give street and number)

1300 E. LANVALE STREET, APT. 226

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

219-14-040

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1-31-26

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1300 E. Lanvale Street Apt. 226

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Other People Homes

17. Father's Name (First, Middle, Last)

Unkn

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Walls

19a. Informant's Name/Relationship (Type, Print)

Minnie E. Jones Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1556 Shetfield Rd., Baltimore, Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Mem. Pk.

Date

1-23-04

20c. Location - City or Town, State

Randallstown, Md.

21. Signature of Funeral Service Licensee

Joseph R. Walters

22. Name and Address of Facility

Baltimore, Md. 21202  
March F.H. East 1101 E. North Ave.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Hyperlipidemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. S. RAMESH

29c. License number

D 35082

29d. Date signed (Month, Day, Year)

1/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2323 Orleans St, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01705

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Virginia Cohee

2. Date of Death

January 21, 2004

3. Time of Death

12:01 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

201 Kennard Avenue

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

Funeral Director

5. Social Security Number

214-14-7027

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

8. Date of Birth (Month, Day, Year)

Nov. 8, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County  
Harford

10c. City, Town or Location  
Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

201 Kennard Avenue

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner / Operator

16b. Kind of Business/Industry

Boat Rental

17. Father's Name (First, Middle, Last)

Vernon Gresham Corrie

18. Mother's Name (First, Middle, Maiden Surname)

Laura Elizabeth White

19a. Informant's Name/Relationship (Type, Print)

Nancy E. Spencer / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3333 Abingdon Road, Abingdon, Maryland 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Grns 1-24-04

Date

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

*Charles A. Engel*

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cerebrovascular Accident*

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Atherosclerotic Cardiovascular Disease*

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Dementia*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Peter L. Forrest, MD*

29c. License number

H39022

29d. Date signed (Month, Day, Year)

January 22 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER L. FORREST, MD 1308 Business Center Way Edgewood MD 21042

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 402A.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01706

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John Cook Jr.

2. Date of Death

January 19, 2004

3. Time of Death

1:10 AM

4a. Facility Name (If not institution, give street and number)

Catonsville Commons

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

215-09-1063

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 5, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

407 Gaither Ave.

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Records Manager

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

John Cook Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Cook

19a. Informant's Name/Relationship (Type, Print)

Mrs. Martha Cook (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

407 Gaither Ave. Catonsville, Md. 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem. Park

Date

1/29/2004

20c. Location - City or Town, State

Arbutus, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
12222 W. North Ave. Balt. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
1-2 weeks

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension  
Hypothyroidism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph L. Russ, Attending Physician

29c. License number

D53642

29d. Date signed (Month, Day, Year)

Jan. 26 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

X/AD21004 5601 Loch Raven Blvd 303 Balt. Md 21239

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01707

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Edward Carter Jr.

2. Date of Death

January 16, 2004 9:04 P M

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

212-88-2910

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

28

8. Date of Birth

Dec. 7, 1975

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5222 Ready Ave.

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Restaurant Worker

16b. Kind of Business/Industry

McDonalds

17. Father's Name (First, Middle, Last)

John Edward Carter Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Taylor

19a. Informant's Name/Relationship (Type, Print) (mother)

Mrs. Phyllis Briggs

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5222 Ready Ave. Balto. Md. 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

1/22/2004

20c. Location - City or Town, State

Dundalk, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot wounds (2) to torso

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☒ Homicide

28a. Date of Injury (Month, Day Year)

01-16-2004

28b. Time of Injury

8:22 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

At home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

997 Honeywood Place, Essex, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph L. Russ

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 17, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21211111111111111111

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Benjamin B. Spaulding

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01708

Certificate of Death

Reg. No.

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

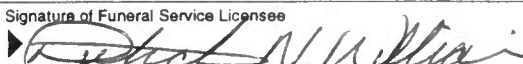
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>EDWARD CLYDE DANGERFIELD JR.</b>		2. Date of Death Month <b>JAN.</b> Day <b>19</b> Year <b>2004</b>		3. Time of Death <b>4:15A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>2688 EAGLE STREET</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Deeth <b>NIA</b>	
5. Social Security Number <b>216-36-7424</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 14, 1942</b>
Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>			
10a. State <b>MARYLAND</b>	10b. County <b>NIA</b>	10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2688 EAGLE STREET</b>		10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>USA.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 YRS</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MAINTENANCE ASSISTANT</b>		16b. Kind of Business/Industry <b>MD. STATE HIGHWAY DEPT.</b>	
17. Father's Name (First, Middle, Last) <b>EDWARD C. DANGERFIELD SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARY E. HARRIS</b>			
19a. Informant's Name/Relationship (Type, Print) <b>LOUISE DANGERFIELD (WIFE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2688 EAGLE ST., BALTIMORE MD. 21223</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		20c. Location - City or Town, State <b>01-26-04 OWINGS MILLS, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic gastric Cancer</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  MD		29c. License number <b>D39127</b>		29d. Date signed (Month, Day, Year) <b>1/22/2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A. AHMED 821 N Eutaw ST Baltimore MD 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01709

1- For  
State  
Registrar

AMEND ITEM #1 PER PHY G828 2/10/04 Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) George H. Dernoeden, Jr. 2. Date of Death January 19 2004 3. Time of Death 7-20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Forest Haven Nursing Center 4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore

5. Social Security Number 170-36-8767 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 59 Yrs. 8. Date of Birth (Month, Day, Year) June 7, 1944 9. Birthplace (State or Foreign Country) Pennsylvania

Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Catonsville 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 701 Edmondson Avenue 10f. Zip Code 21228 10g. Citizen of What Country? U.S.A.

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sports Editor 16b. Kind of Business/Industry Newspaper

17. Father's Name (First, Middle, Last) George H. Dernoeden, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Margaret Sheck

19a. Informant's Name/Relationship (Type, Print) Peter Dernoeden (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2234 Daisy Road Woodbine, Maryland 21797

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Thomas Epis. Church Cemetery Date 1-24-2004 20c. Location - City or Town, State Whitemarsh, PA

21. Signature of Funeral Service Licenses [Signature] 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Parkinson's disease Due to (or as a consequence of): Fronto temporal lobe degeneration Schizophrenia

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroidism 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 26. Place of Death (Check only one)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Amatun N. Naeem MD 29c. License number D15503 29d. Date signed (Month, Day, Year) January 19 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMATUN N. NAEEM 501 Dolphin St, Baltimore MD 21217

31. Date filed (Month, Day, Year) JAN 23 2004 32. Registrar's Signature [Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01710

1- For State Registrar

AMEND ITEM #30 PER DVR C827 1/23/04 JR

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Marie Dixon Dill

2. Date of Death  
Month Day Year

01 08 2004

3. Time of Death

8:00 P M

Funeral Director

4a. Facility Name (If not institution, give street and number)

Chestertown Nurs & Rehab Ctr. Chestertown

4b. City, Town, or Location of Death

4c. County of Death

Kent

5. Social Security Number

212-10-3250

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

08-20-1916 Md.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Md.

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

415 Morgue Road

10f. Zip Code

21620

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

clerk

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

William Walter Dixon

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Leola Strube

19a. Informant's Name/Relationship (Type, Print)

Joyce Redmond/stepdaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8280 Bakers Lane Chesterstown, MD 21620

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death  
CURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John C Seymour

29c. License number

0-0013824

29d. Date signed (Month, Day, Year)

1-14-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN C SEYMOUR CHARLESTOWN NURSING & REHAB CENTER CHESTERTOWN MD

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01711

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, this Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Eugene Ellsworth Ewing</b>				2. Date of Death Month <b>January</b> Day <b>17</b> Year <b>2004</b>		3. Time of Death <b>2:00 a</b> <sup>M</sup>	
4a. Facility Name (If not institution, give street and number) <b>110F Seevue Court</b>				4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>	
5. Social Security Number <b>215-30-3322</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 8, 1934</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		Usual Residence of Decedent					
10a. State <b>Md.</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>110F Seevue Court</b>				10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b> College (1-4or 5+) <b>foreman</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>foreman</b>		16b. Kind of Business/Industry <b>steel</b>	
17. Father's Name (First, Middle, Last) <b>Ellsworth Ewing</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Julia Moore</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Margaret Woodward/Personal Rep.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1505 Wildwood Drive, Fallston, Md. 21047</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		Date <b>1/21/2004</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Coronary Artery disease</b> Due to (or as a consequence of): b. <b>Aortic Valve Replacement</b> Due to (or as a consequence of): c. <b>Chronic obstructive Pulmonary Disease</b> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D20649</b>		29d. Date signed (Month, Day, Year) <b>1/20/2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John W. Bowie, M.D., 6701 North Charles St., Baltimore, Md.</b>							
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>				32. Registrar's Signature 			

Replacement

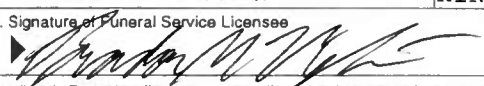


Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For Unpend Item #23a-b, pt. II, 27, 28a-f per me G829 3/15/04 tas  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2004-01712

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>EDITH ENNIS</b>		2. Date of Death Month Day Year <b>JAN. 20, 2004</b>		3. Time of Death <b>5:25 p M</b>	
4a. Facility Name (If not institution, give street and number) <b>LEVINDALE HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>NA</b>	
5. Social Security Number <b>212-28-6211</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>JUL. 9, 1925</b>		9. Birthplace (State or Foreign Country) <b>MD</b>			
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2038 BRADDISH AVENUE</b>		10f. Zip Code <b>21216</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>AFRICAN AMERICAN</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC</b>		16b. Kind of Business/Industry <b>HOMES</b>	
17. Father's Name (First, Middle, Last) <b>WILLIAM JOHNSON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>EDITH MASON</b>			
19a. Informant's Name/Relationship (Type, Print) <b>EARL ENNIS (SON)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2038 BRADDISH AVENUE BALTIMORE, MD 21216</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PK.</b>		20c. Location - City or Town, State <b>1/26/2004 BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CEREBROVASCULAR INFARCTION COMPLICATED BY HYPOXIA</b> Due to (or as a consequence of): <b>LACK OF HUMIDIFIED OXYGEN</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Due to (or as a consequence of):</b> <b>Due to (or as a consequence of):</b> <b>Due to (or as a consequence of):</b>		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year <b>2</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>DIABETES MELLITUS</b> <b>STATUS POST CEREBRAL ANEURYSM CLIPPING</b>					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>1-20-04</b>		28b. Time of Injury <b>unknown</b> M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>WALL UNIT OXYGEN TURNED OFF</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>2434 W. BELFORD AVE. BALTIMORE, MARYLAND</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JAN. , 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY C. RIPLE, MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>MAR 15 2004</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01713

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES JOHN ESHINSKY</b>				2. Date of Death Month <b>January</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>12:15 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>3802 Walters Road</b>				4b. City, Town, or Location of Death <b>Edgewood</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>211-22-0991</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 2, 1915</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Edgewood</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3802 Walters Road</b>		10f. Zip Code <b>21040</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1940-45</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinest</b>		16b. Kind of Business/Industry <b>U.S. Government</b>				
17. Father's Name (First, Middle, Last) <b>John u/k Eshinsky</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Tekla u/k Borawska</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ethel R. Eshinsky - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3802 Walters Road, Edgewood, Maryland 21040</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Grdns.</b>		20c. Location - City or Town, State <b>1/24/04 Bel Air, Maryland</b>				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>Failure to thrive</b> Due to (or as a consequence of):		b. <b>Parkinsons ds</b> Due to (or as a consequence of):		c. <b>Hydrocephalus</b> Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		d. <b></b>		Approximate Interval Between Onset and Death <b>~ 1 yr</b> <b>~ 10 yrs</b> <b>~ 1-2 yrs</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CAD</b> <b>Polymyalgia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> MD, FACP		29c. License number <b>D50040</b>		29d. Date signed (Month, Day, Year) <b>01-20-04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1308 Business Ctr Way #102, Edgewood, MD 21040</b>		31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <i>[Signature]</i>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01714

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carolyn P. Fisher				2. Date of Death Month Day Year January 18 2004		3. Time of Death 1407 p m						
	4a. Facility Name (If not institution, give street and number) 1645 Ramblewood Road				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A						
Funeral Director	5. Social Security Number 217-38-1596		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) August 31, 1940		9. Birthplace (State or Foreign Country) North Carolina				
	Usual Residence of Decedent				10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1645 Ramblewood Road				10f. Zip Code 21239				10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Lionel G. Paul				18. Mother's Name (First, Middle, Maiden Surname) Lela Godley									
19a. Informant's Name/Relationship (Type, Print) Lyon Fisher - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 South George Mason Drive Apt. 2404 Falls Church, VA 22041									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 1/23/04		20c. Location - City or Town, State Baltimore, Maryland					
21. Signature of Funeral Service Licensee Heather Cain				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic alcoholism				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Ling Li, M.D.				29c. License number OCME		29d. Date signed (Month, Day, Year) January 19 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI, M.D.				111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JAN 23 2004				32. Registrar's Signature Karin H. Spivey									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1- For  
State  
Registrar

Amend Item 26 per verb., G82701/23/04 Certificate of Death

Reg. No.

2004 01715

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy M. Fisher

2. Date of Death

Month Day Year  
January 15, 2004 3:00 P.<sup>M</sup>

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-12-7378

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 26, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2095 Rock Rose Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own Home

17. Father's Name (First, Middle, Last)

Jessie E. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Annie E. Jenkins

19a. Informant's Name/Relationship (Type, Print)

Floyd Smith Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1720 Woodstock Road Woodstock, Maryland 21163

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore National

Date

1/20/2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Rym B. Henss

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc. 21211  
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

b. Senile Dementia

Due to (or as a consequence of):

c. Cardio-pulmonary arrest

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rym B. Henss

29c. License number

D30115

29d. Date signed (Month, Day, Year)

1/16/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Ohiokepe, MD 2600 Liberty HILLS AVE Baltimore MD 21215

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Rym B. Henss

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01716

Certificate of Death

Reg. No.

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified in advance.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Juanita France</i>		2. Date of Death Month <i>JANUARY</i> Day <i>21</i> Year <i>2004</i>		3. Time of Death <i>11:10 AM</i>	
4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Care Center</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
5. Social Security Number <i>412-10-8504</i>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>82</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>Aug. 1, 1921</i>	9. Birthplace (State or Foreign Country) <i>Tennessee</i>	
Usual Residence of Decedent					
10a. State <i>Maryland</i>	10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore City</i>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <i>1510 Ramsey Street</i>		10f. Zip Code <i>21123</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Shirt Presser</i>		16b. Kind of Business/Industry <i>Manufacturer</i>			
17. Father's Name (First, Middle, Last) <i>Driscoll Edward Stepp</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Hannah Elizabeth Harrison</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Hattie E. Stepp (Sister in Law)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5700 Carrington Dr., White Marsh, MD 21162</i>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Loudon Park Cemetery</i>		20c. Location - City or Town, State <i>1/24/04 Baltimore, Maryland</i>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>ARRHYTHMIA</i> Due to (or as a consequence of): b. <i>HYPONEMIA</i> Due to (or as a consequence of): c. <i>RESPIRATORY FAILURE</i> Due to (or as a consequence of): d. <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i>					
Approximate Interval Between Onset and Death <i>MINUTES</i> <i>MINUTES</i> <i>MONTHS</i> <i>YEARS</i>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month <i></i> Day <i></i> Year <i></i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia, CORONARY ARTERY DISEASE, CEREBROVASCULAR ACCIDENT, RIGHT UPPER EXTREMITY ARTERIAL EMBOLUS/CLOT</i>					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <i></i>		28b. Time of Injury <i>M</i>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred <i></i>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i></i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i></i>			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D04383</i>		29d. Date signed (Month, Day, Year) <i>JANUARY 21, 2004</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>William Greenough 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE MD 21224</i>					
31. Date filed (Month, Day, Year) <i>JAN 23 2004</i>		32. Registrar's Signature <i>[Signature]</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per fh 845 7-15-05 vt

State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01717

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Rita Anna Fox				2. Date of Death Month January Day 20, Year 2004				3. Time of Death 8:34A M	
4a. Facility Name (If not institution, give street and number) 11820 Gontrum Road				4b. City, Town, or Location of Death Kingsville				4c. County of Death Baltimore	
5. Social Security Number 216-24-2459		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 4, 1928		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent									
10a. State MD		10b. County Baltimore		10c. City, Town or Location Kingsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 11820 Gontrum Road				10f. Zip Code 21087		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Operator			16b. Kind of Business/Industry AT&T		
17. Father's Name (First, Middle, Last) Julius Weiss				18. Mother's Name (First, Middle, Maiden Surname) Barbara Anna Huber					
19a. Informant's Name/Relationship (Type, Print) Leonard Fox (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11820 Gontrum Road Kingsville, Maryland 21087					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem		Date 1/23/04		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee Cezelone				22. Name and Address of Facility Miller-Dippel Funeral Home, INC. 6415 Belair Road Baltimore, Maryland 21206					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death years									
23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown									
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown									
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death Check on one Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Rita Anna Fox				29c. License number D70673		29d. Date signed (Month, Day, Year) 1/21/04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cezelone 7072 Belair Road, Baltimore, MD 21236									
31. Date filed (Month, Day, Year) JAN 23 2004				32. Registrar's Signature John B. Smith					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01718

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine Gohlinghorst</b>				2. Date of Death Month <b>January</b> Day <b>18</b> Year <b>2004</b>				3. Time of Death <b>5 P M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>				4b. City, Town, or Location of Death <b>Randallstown</b>				4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212-22-0837</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>09-10-1926</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3434 Abbie Place</b>				10f. Zip Code <b>21244</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>07</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>			16b. Kind of Business/Industry <b>Food Service</b>			
17. Father's Name (First, Middle, Last) <b>Frank J. Gross</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Hilda Mary Martin</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Rosemary Schroen</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1638 Coon Road Asbers, Pa 17304</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens Of Faith</b>		Date <b>01-23-2004</b>		20c. Location - City or Town, State <b>Baltimore</b>			
21. Signature of Funeral Service Licensee <b>Cheryl Luse</b>					22. Name and Address of Facility <b>Loring Byers Funeral Directors Inc 8728 Liberty Road Randallstown, Maryland 21133</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Acute respiratory failure</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. <b>Non operable lung cancer</b> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>12 hours</b> <b>&gt; 12 hours</b> <b>&gt; 2 years</b>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary artery disease</b> <b>Hypertension</b> <b>Chronic obstructive pulmonary disease</b>							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>J Boston MD</b>					29c. License number <b>028462</b>		29d. Date signed (Month, Day, Year) <b>January 18, 2004</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J Boston Northwest Hospital Center Randallstown Maryland 21133</b>										
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>					32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, **A Medical Examiner must be notified at once.**

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

HONG GUO  
04-00166  
UNK 04-009  
DAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01719

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>HONG GUO</b>		2. Date of Death Month <b>JANUARY</b> Day <b>7</b> Year <b>2004</b>		3. Time of Death <b>12:55a M</b>	
4a. Facility Name (If not institution, give street and number) <b>6304 EASTERN AVENUE</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death	
5. Social Security Number <b>UNKNOWN</b>		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>39</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>3/1/1964</b>		9. Birthplace (State or Foreign Country) <b>CHINA</b>			
10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>BALTIMORE CITY</b>	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>6304 EASTERN AVENUE</b>		10f. Zip Code <b>21224</b>	
10g. Citizen of What Country?		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>ASIAN</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COMPUTER</b>		16b. Kind of Business/Industry <b>CONSTRUCTION CO.</b>	
17. Father's Name (First, Middle, Last) <b>UNK</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>UNK</b>			
19a. Informant's Name/Relationship (Type, Print) <b>XIN MIN WU - HUSBAND</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>65 RIVINGTON ST., APT. 7, NEW YORK, NY 10002</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREENWOOD CREMATORY</b>		20c. Location - City or Town, State <b>1/17/2004 Brooklyn, NY</b>	
21. Signature of Funeral Service Licensee <b>KELLY GREGORY FINK #MO1148</b>		22. Name and Address of Facility <b>FINK FUNERAL HOME, PA</b> <b>426 CRAIN HWY., S, GLEN BURNIE, MD 21061</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Strangulation</b>		Approximate Interval Between Onset and Death			
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):			
		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>	
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>UNK</b>		28b. Time of Injury <b>UNK</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject strangled</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Residence</b>	
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6304 Eastern Ave</b>		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>	
29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 7, 2004</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Wilson Locke, MD</b>		31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01720

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and complete it filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Mary Gorman Gary</b>		2. Date of Death Month Day Year <b>January 1, 2004</b>		3. Time of Death <b>8:45 PM<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>12299 Dixie Drive</b>		4b. City, Town, or Location of Death <b>Bishopville</b>		4c. County of Death <b>Worcester</b>	
5. Social Security Number <b>218-18-6786</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Sept 11, 1915</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Worcester</b>	10c. City, Town or Location <b>Bishopville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>12299 Dixie Drive</b>		10f. Zip Code <b>21813</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>cashier</b>		16b. Kind of Business/Industry <b>food</b>			
17. Father's Name (First, Middle, Last) <b>Charles B. gorman</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Belle Dorsey</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mary Abell/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12299 Dixie Drive Bishopville, MD 21813</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <i>Ronald S. Wade</i>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Lung Cancer</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
Approximate Interval Between Onset and Death <b>years</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and Title of certifier <i>Ronald S. Wade</i>		29c. License number <b>D28769</b>		29d. Date signed (Month, Day, Year) <b>1/9/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nicholas N. Borodulica, MD 1209 Coastal Highway Fawcett, DE 19944</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <i>Ronald S. Wade</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01721

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eugene

Galek

2. Date of Death

Month

Day

Year

January

19

2004

3. Time of Death

1045

M

4a. Facility Name (If not institution, give street and number)

Jenns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

217-38-4363

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

June 2, 1941

9. Birthplace (State or Foreign

Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

132 North Rose Street

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

store keeper

16b. Kind of Business/Industry

Bureau of Purchasing-  
City of Baltimore

17. Father's Name (First, Middle, Last)

Joseph Galek

18. Mother's Name (First, Middle, Maiden Surname)

Elaine Carlisle

19a. Informant's Name/Relationship (Type, Print)

Eugene J. Galek, Jr. - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5615 Knell Avenue Baltimore, Maryland 21206

20a. Method of Disposition

☒ Burial☐ Cremation☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Woodlawn Cemetery

Date

1/23/2004

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Charles S. Zeiler &amp; Son, Inc.

6224 Eastern Avenue Baltimore, Maryland 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastric Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Could not be determined☐ Suicide☐ Homicide☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 19 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Stephens, M.D. 600 N. Wolfe St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

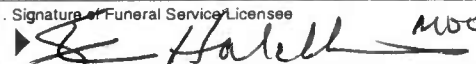
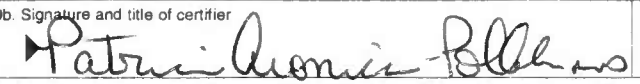

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 01722  
Certificate of Death

1- For  
State  
Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward J. Holland				2. Date of Death Month Day Year JAN. 22, 2004				3. Time of Death 12:35 P M			
	4a. Facility Name (If not institution, give street and number) 524 NORTH CHARLES STREET APT.213				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death N/A			
Funeral Director	5. Social Security Number 215-22-3636		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Jun 24, 1927		9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 524 N. Charles Street, Apt. 1213				10f. Zip Code 21201		10g. Citizen of What Country? United States					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance				16b. Kind of Business/Industry City of Baltimore			
	17. Father's Name (First, Middle, Last) Edward Jerome Holland, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Irene Elizabeth Parker							
	19a. Informant's Name/Relationship (Type, Print) Mrs. Gloria C. Terrell/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Winesap Court, Catonsville, MD 21228							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date Jan 23 2004		20c. Location - City or Town, State Beltsville, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. atherosclerotic cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier  29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) JAN. 22, 2004												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA ARONICA POLIAKOVA 11 Penn Street, Baltimore, Maryland 21201												
31. Date filed (Month, Day, Year) JAN 23 2004 32. Registrar's Signature 												

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01723

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9059.

Division of Vital Records, P.O. Box 68760,

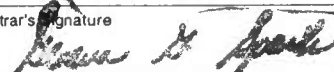
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Carl Wayne Harkleroad</b>		2. Date of Death Month <b>January</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>3:21 P M</b>	
4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Ctr.</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>414-34-7911</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>75</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Aug. 25, 1928</b>		9. Birthplace (State or Foreign Country) <b>Tennessee</b>			
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>	
10d. Inside City Limits <b>1 Yes 2 No</b>					
10e. Street and Number <b>2011 Inverton Road</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates: <b>Korean</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify: <b>White</b>	
14. Race - American Indian, Black, White, etc. <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11 Years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Millwright</b>		16b. Kind of Business/Industry <b>Steel Industry</b>	
17. Father's Name (First, Middle, Last) <b>John Harkleroad</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Nola Anderson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Mary Sue Harkleroad (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2011 Inverton Road Dundalk, Maryland 21222</b>			
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		20c. Location - City or Town, State <b>1/23/2004 Towson, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute RESPIRATORY FAILURE</b>		23b. Immediate Cause (Final disease or condition resulting in death) <b>Chronic obstructive Lung Disease</b>		Approximate Interval Between Onset and Death	
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Due to (or as a consequence of):			
23e. Due to (or as a consequence of):		23f. Due to (or as a consequence of):			
23g. Due to (or as a consequence of):		23h. Due to (or as a consequence of):			
23i. Due to (or as a consequence of):		23j. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>		23d. Date of delivery Month <b>01</b> Day <b>22</b> Year <b>2004</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>			
24a. Was an autopsy performed? <b>1 Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>			
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>			
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day Year) <b>1 M 2 No</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. Signature and title of certifier <b>DMT - E. M. M.</b>		29c. License number <b>D 0021859.</b>	
29d. Date signed (Month, Day, Year) <b>01/22/2004</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MOHAMMAD TAQI MD 23 SHIPPING PL Baltimore MD 21222</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01724

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM HUGHES Sr

2. Date of Death

Month

Day

Year

JAN 17 2004

3. Time of Death

02:50

4a. Facility Name (If not institution, give street and number)

Genesis Elder Care

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-58-4144

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

07 27 52

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3606 Spaulding Ave

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

2yrs

17. Father's Name (First, Middle, Last)

William Buddy Hughes

18. Mother's Name (First, Middle, Maiden Summa)

Doris McMillion

19a. Informant's Name/Relationship (Type, Print)

Tanya Hughes-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

426 North Robinson Street, Balto, Md 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

King Memorial Park

Date

1/23/04

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

Hebece Ed

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

DAYS

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

DAYS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. J. P. MD

29c. License number

00053150

29d. Date signed (Month, Day, Year)

JAN 22nd 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARUNMAA GUPTA MD 201-109 BACHMAN NECLRD 21221

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01725

1- For State Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) RAYMOND JOSEPH HYZA			2. Date of Death Month Day Year January 19, 2004			3. Time of Death 12:01 A <sup>M</sup>								
4a. Facility Name (If not institution, give street and number) 56 Anchor Way			4b. City, Town, or Location of Death Berlin			4c. County of Death Worcester								
5. Social Security Number 219-40-9146		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) 11/24/1943		9. Birthplace (State or Foreign Country) MARYLAND							
Usual Residence of Decedent														
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location CARNEY			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 9100 COVERED BRIDGE ROAD				10f. Zip Code 21234		10g. Citizen of What Country? USA								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YEARS College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ACCOUNTANT			18b. Kind of Business/Industry SOCIAL SECURITY ADMINISTRATION								
17. Father's Name (First, Middle, Last) JOSEPH HYZA					18. Mother's Name (First, Middle, Maiden Surname) HILDEGARD RAABE									
19a. Informant's Name/Relationship (Type, Print) KATHLEEN L. HYZA WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9100 COVERED BRIDGE RD. CARNEY, MD 21234										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) DULLANEY VALLEY MEM. GARDENS		Date 1/24/2004		20c. Location - City or Town, State TIMONIUM, MD							
21. Signature of Funeral Service Licensee <i>Kathleen L. Hyza</i>				22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypothermia complicating atherosclerotic cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)				23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) Found 1-19-04		28b. Time of Injury Found 12:01 A <sup>M</sup>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject was exposed to cold					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) back yard			28f. Location (Street and Number or Rural Route Number, City or Town, State) 56 Anchor Way Berlin, MD								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29b. Signature and title of certifier <i>Raymond J. Hyza M.D.</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 20, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI, M.D. 111 Penn Street, Baltimore, Maryland 21201														
31. Date filed (Month, Day, Year) JAN 23 2004			32. Registrar's Signature <i>Raymond J. Hyza</i>											

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01726

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Willie Lee Holland

2. Date of Death

January 20 2004

Day

Year

3. Time of Death

9:40 AM

4a. Facility Name (If not institution, give street and number)

Unin Mem. Hosp.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

245-34-9107

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9-5-27

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

401 E. 25th St. Apt. 4N

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7th grade

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Walker

18. Mother's Name (First, Middle, Maiden Surname)

Holland

19a. Informant's Name/Relationship (Type, Print)

Lois Holland Wife

401 E. 25th St. Apt. 4 N, Baltimore, Md. 21218

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Lois Holland Wife

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King Mem. Pk.

Date

1-26-04

20c. Location - City or Town, State

Randallstown, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Baltimore, Md. 21202  
March F.H. East 1101 E. North Ave.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Methicillin Resistant Staphylococcus Aureus Pneumonia

Approximate  
Interval Between  
Onset and Death

1 week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Chronic Obstructive Pulmonary Disease Exacerbation

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Heart Disease

Congestive Heart Failure

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D0056046

29d. Date signed (Month, Day, Year)

January 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Gao, M.D. The Union Memorial Hospital, Baltimore, MD 21218

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

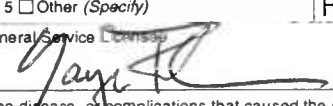
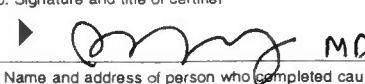
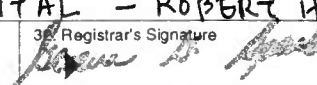
State of Maryland / Department of Health and Mental Hygiene

2004 01727

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MIRIAM HIMMELSTEIN</b>		2. Date of Death Month Day Year <b>January 20 2004</b>		3. Time of Death <b>9:11 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>212-22-4323</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>SEPT. 6, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number <b>6212 WOODCREST AVENUE</b>		10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>
	17. Father's Name (First, Middle, Last) <b>JACOB COOPER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>REBA FADER</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>MORRIS HIMMELSTEIN / HUSBAND</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6212 WOODCREST AVENUE - BALTIMORE, MD 21209</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW YOUNG MEN</b>		20c. Location - City or Town, State <b>1/22/2004 WOODLAWN, MD</b>
	21. Signature of Funeral Service Director 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Cardiogenic Shock</b> Due to (or as a consequence of): b. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier  <b>MD</b>		29c. License number <b>19026</b>		29d. Date signed (Month, Day, Year) <b>January 20 2004</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SINAI HOSPITAL - ROBERT HONG, MD</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01728

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas M. Hopkins				2. Date of Death Month Day Year January 4, 2004				3. Time of Death 6:42 AM M		
	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice				4b. City, Town, or Location of Death Baltimore				4c. County of Death		
Funeral Director	5. Social Security Number 091-24-5770		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Apr 9, 1923		9. Birthplace (State or Foreign Country) New Jersey		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 719 Maiden Choice Lane BRT-33				10f. Zip Code 21228		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: '43-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) biologist				16b. Kind of Business/Industry unk		
	17. Father's Name (First, Middle, Last) Thomas Smith Hopkins				18. Mother's Name (First, Middle, Maiden Surname) Louisa Clement						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ruth Hopkins/spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Lane BRT-33 Catonsville, MD 21228						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic obstructive pulmonary disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death years										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Hospice							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier CD Kearney MD				29c. License number D0027860				29d. Date signed (Month, Day, Year) January 4th, 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTOPHER D. KEARNEY MD 201 E. Univ Pkwy Balt. Md 21218											
31. Date filed (Month, Day, Year) JAN 23 2004				32. Registrar's Signature [Signature]							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01729

## Certificate of Death

Reg. No.

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jim H. Hawker

2. Date of Death

January 13 2004

3. Time of Death

0312 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

228-19-8312

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept 20, 1940

9. Birthplace (State or Foreign Country)

unk

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5 Girard Drive

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

unk

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

unk

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4or 5+)

unk

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

unk

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Sinai Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2401 W. Belvedere Avenue Baltimore, MD 21215

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. [Signature] Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Prostate Cancer (end stage)

Due to (or as a consequence of):

b. Overwhelming sepsis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

James E. Stone, M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 13, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James E. Stone, M.D. 2401 West Belvedere Avenue Baltimore, MD 21215

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State  
Registrar

ORIGINAL

Patient known as: Hawker, Jim H.  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01730

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George Franklin Hoffman</b>				2. Date of Death Month <b>January</b> Day <b>17</b> Year <b>2004</b>				3. Time of Death <b>2:15 A<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>Quail Run Elder Care Community</b>				4b. City, Town, or Location of Death <b>Perry Hall</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>214-16-7934</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 26, 1920</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Overlea</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>5608 Daybreak Terrace</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Explosive Technician</b>			16b. Kind of Business/Industry <b>Government</b>			
17. Father's Name (First, Middle, Last) <b>George F. Hoffman</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Smith</b>					
19a. Informant's Name/Relationship (Type, Print) <b>John Hoffman (Son)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12534 Valley View Street No. 311 Garden Grove, CA 92845</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery</b>			20c. Location - City or Town, State <b>Baltimore, MD</b>			
21. Signature of Funeral Service Licensee <i>Elizabeth Selenski</i>					22. Name and Address of Facility <b>Miller-Dippel Funeral Home, Inc. 6415 Eastern Avenue Baltimore, MD 21206</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Cancer with unknown Primary</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>un-known</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Compression fracture Lumbar Vertebrae Multi infarct Dementia, CVA.</b>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>M.D.</i>			29c. License number <b>D-38754</b>		29d. Date signed (Month, Day, Year) <b>01-22-2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SAI MALIKA WASEEM 709 EASTERN BLVD MD-21221</b>										
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01731

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Lucretia</b>		2. Date of Death Month <b>January</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>00:26</b> M	
4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>220-14-3831</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Oct. 30, 1918</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore City</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1300 South Ellwood Avenue</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	
16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>William O'Neill</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lucretia Bond</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Mary Hart- daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>518 South Bouldin Street Baltimore, Maryland 21224</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Assunta Hogg</b>		22. Name and Address of Facility <b>Charles S. Zeiler &amp; Son, Inc. 6224 Eastern Avenue Baltimore, Maryland 21224</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>Sepsis</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>Two weeks</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Wina Munt MD</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>January 20, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nisa Maruthur 600 North Wolfe Street Baltimore, Maryland 21287</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

DCS  
04-00590  
Isaiah J. Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 01732

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Isaiah J. Johnson</b>			2. Date of Death Month <b>January</b> Day <b>21</b> Year <b>2004</b>		3. Time of Death <b>658 a</b> <sup>M</sup>	
	4a. Facility Name (If not institution, give street and number) <b>6511 Insey Street</b>			4b. City, Town, or Location of Death <b>Forestville</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>163-36-1358</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 31, 1942</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>
	10a. State <b>Maryland</b>			10b. County <b>Prince Georges</b>	10c. City, Town or Location <b>Forestville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>6511 Insey Street</b>			10f. Zip Code <b>20747</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Construction</b>	
	17. Father's Name (First, Middle, Last) <b>Isaiah Johnson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Dora Anderson</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Corrine Mansfield-Sister</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>519 Imboden Street #101 Alexandria, Va. 22304</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pleasant Valley</b>		20c. Location - City or Town, State <b>1/28/04 Annandale, virginia</b>		20d. Date
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Robert B. Baker Jr.</b>			22. Name and Address of Facility <b>Chinn Funeral Service</b> <b>2605 S. Shirlington Rd Arlington, Va. 22206</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Atherosclerotic Cardiovascular disease</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Chronic alcoholism</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						Approximate Interval Between Onset and Death
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier <b>Zaburud Ali</b>
	29c. License number <b>OCME</b>						29d. Date signed (Month, Day, Year) <b>January 21 2004</b>
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ZABURUD ALI</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>						
	31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>						32. Registrar's Signature <b>B. Sparks</b>

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 01733

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Barbara Jones</b>		2. Date of Death Month Day Year <b>January 18, 2004</b>		3. Time of Death <b>3:20 a.m.</b>
	4a. Facility Name (If not institution, give street and number) <b>Maryland General Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>NA</b>
Funeral Director	5. Social Security Number <b>212-28-2344</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>3-2-32</b>	9. Birthplace (State or Foreign Country) <b>Va.</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1100 W. Pennsylvania Ave. Apt. 411</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) <b>8th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing Assit.</b>		16b. Kind of Business/Industry <b>Hospital</b>
	17. Father's Name (First, Middle, Last) <b>Vernon Parham</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lossi Lucas</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Sheila Wooten Daughter-in-law</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11709 South River Patch Dr., Midlothian, Va. 23113</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk.</b>		20c. Location - City or Town, State <b>1-21-04 Randallstown, Md.</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Md. 21202</b> <b>March F.H. East 1101 E. North Ave.</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Arrhythmia</b> Due to (or as a consequence of): b. <b>Vocal Cord Paralysis</b> Due to (or as a consequence of): c. <b>Aspiration Pneumonia</b> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier M.D.		29c. License number <b>89506</b>		29d. Date signed (Month, Day, Year) <b>1-18-04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHAHID WAZIR M.D. C/o Maryland General Hospital</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01734

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9056.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Elizabeth Jefferson</b>		2. Date of Death Month <b>January</b> Day <b>16</b> Year <b>2004</b>		3. Time of Death <b>1650 M</b>	
4a. Facility Name (If not institution, give street and number) <b>Union Mem. Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
5. Social Security Number <b>217-20-0046</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>1-1-22</b>
9. Birthplace (State or Foreign Country) <b>Va.</b>					
Usual Residence of Decedent					
10a. State <b>Md.</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2008 Robb Street</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>10th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dictary</b>		16b. Kind of Business/Industry <b>J.H.H.</b>	
17. Father's Name (First, Middle, Last) <b>Unkn</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lula Clark</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Denise Lowery Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2008 Robb Street, Baltimore, Md. 21218</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk.</b>		20c. Location - City or Town, State <b>1-24-04 Arbutus Md</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Md. 21202</b> <b>March F.H. East 1101 E. North Ave.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Right Ventricle Failure secondary to myocardial infarction</b>					
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>AT2438946</b>		29d. Date signed (Month, Day, Year) <b>January 16th 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SANDEEP SHARMA MD DEA # AF23284123209 201 EAST UNIVERSITY PKWY BALTIMORE, MD 21218</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01735

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Emma Joyce</i>		2. Date of Death Month <i>01</i> Day <i>20</i> Year <i>2004</i>		3. Time of Death <i>9:55 a M</i>
	4a. Facility Name (If not institution, give street and number) <i>Future Care Canton Harbor</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death
Funeral Director	5. Social Security Number <i>218-22-2364</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>84</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>05-22-1919</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	10a. State <i>Maryland</i>		10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore City</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>2613 Llewelyn Avenue</i>		10f. Zip Code <i>21213</i>
	10g. Citizen of What Country? <i>U.S.A.</i>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>
	17. Father's Name (First, Middle, Last) <i>John Becker</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Emma Young</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>Nan Joyce-Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2613 Llewelyn Avenue Baltimore, Maryland 21213</i>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Oaklawn Cemetery</i>		20c. Location - City or Town, State <i>1/23/2004 Baltimore, Maryland</i>
	21. Signature of Funeral Service Licensee <i>Michael Hagg</i>		22. Name and Address of Facility <i>Miller-Dippel Funeral Home 6415 Belair Road Baltimore, Maryland 21206</i>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death. Immediate Cause (Final disease or condition resulting in death) <i>Aspirative Pneumonia</i>				Approximate Interval Between Onset and Death <i>2 weeks</i>
	Sequentially list conditions, if any, leading to immediate cause. Enter in descending order of causality. Cause (Disease or injury that initiated events resulting in death) Last <i>Hypertensive Arteriosclerotic Coronary Artery Disease Pulmonary Embolism Cerebrovascular Disease Dehydration</i>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertensive Arteriosclerotic Coronary Artery Disease Pulmonary Embolism Cerebrovascular Disease Dehydration</i>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Michael Hagg</i>		29c. License number <i>D19667</i>	
29d. Date signed (Month, Day, Year) <i>01-21-2004</i>		29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>1300 South Ellwood Avenue Baltimore, Maryland 21224</i>			
31. Date filed (Month, Day, Year) <i>JAN 23 2004</i>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01736

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Eula O. King

2. Date of Death

Jan 19 2004

3. Time of Death

3:38p M

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

214-38-2093

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 11, 1940

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1104 Roseanda Court

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Meals on Wheels

17. Father's Name (First, Middle, Last)

Guyle Patrick

18. Mother's Name (First, Middle, Maiden Surname)

Anna Belle White

19a. Informant's Name/Relationship (Type, Print)

Wayne J. King

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1104 Roseanda Court Baltimore MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

OakLawnCemetery

Date

1/22/04

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

ConnellyFuneralHomeofEssex  
300 MAce Ave. Baltimore MD 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Tariq Mahmood

29c. License number

D43725

29d. Date signed (Month, Day, Year)

1/19/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

JANUARY 19, 2004 3:38 p.m.

Baltimore, Maryland 21215-0036

EULA KING

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01737

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Elizabeth Kohlhepp

2. Date of Death

January 19, 2004

3. Time of Death

10:20 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

5. Social Security Number

219-80-2551

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

36

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Aug. 15, 1967

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
n/a10c. City, Town or Location  
Baltimore10d. Inside City Limits  
☒ Yes ☐ No

10e. Street and Number

4205 Heckel Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Forensic Psychiatric

16b. Kind of Business/Industry

Social Worker

17. Father's Name (First, Middle, Last)

John D. Kohlhepp

18. Mother's Name (First, Middle, Maiden Surname)

Gloria M. Ostendorf

19a. Informant's Name/Relationship (Type, Print)

John D. Kohlhepp

Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8010 Remington Avenue  
Baltimore, Maryland 21244

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

Jan. 23, 2004 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph J. Kellner M00333

22. Name and Address of Facility

8728 Liberty Rd. Randallstown, MD 21133-4784

Loring Byers Funeral Directors, Inc.

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pericardial Effusion

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sara Calvert MD

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

January 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sara Calvert, 4940 Eastern Avenue, Baltimore, MD 21224

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01738

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDDIE HUBERT KING</b>				2. Date of Death Month Day Year <b>JANUARY 17 2004</b>				3. Time of Death <b>0912</b> M			
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>238-40-8349</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6/30/1927</b>		9. Birthplace (State or Foreign Country) <b>NC</b>			
	Usual Residence of Decedent											
10a. State <b>DC</b>		10b. County		10c. City, Town or Location <b>WASHINGTON</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>1615 NORTH PORTAL DRIVE NW</b>				10f. Zip Code <b>20012</b>				10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REAL ESTATE MANAGER</b>				16b. Kind of Business/Industry <b>REAL ESTATE</b>				
17. Father's Name (First, Middle, Last) <b>SAMUEL SELMON KING</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MARY DAVIS</b>						
19a. Informant's Name/Relationship (Type, Print) <b>EMMA L. KING</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1615 NORTH PORTAL DR NW, WASHINGTON D.C. 20012</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>		Date <b>1/23/2004</b>		20c. Location - City or Town, State <b>WASHINGTON, NC</b>				
21. Signature of Funeral Service Licensee <b>KELLY GREGORY FINK #MO1148</b>				22. Name and Address of Facility <b>FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): b. <b>NEUROGENIC SHOCK</b> Due to (or as a consequence of): c. <b>SPINAL CORD INJURY</b> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death												
23b. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>01-13-2004</b>		28b. Time of Injury <b>10:41</b> A <sup>M</sup>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject driver struck guardrail.</b>				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D0059739</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 17, 2004</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MUNISH Goyal, MD 29 S. GREENE ST. BALTIMORE, MD 21201</b>												
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>				32. Registrar's Signature <b>[Signature]</b>								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01739

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Rosemarie Kesler</i>				2. Date of Death Month <i>January</i> Day <i>21</i> Year <i>2004</i>				3. Time of Death <i>1:50 P M</i>	
	4a. Facility Name (If not institution, give street and number) <i>Harbor Hospital Center</i>				4b. City, Town, or Location of Death <i>BALTIMORE CITY</i>				4c. County of Death <i>n/a</i>	
Funeral Director	5. Social Security Number <i>212-50-6003</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>65</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Jan. 31 1938</i>		9. Birthplace (State or Foreign Country) <i>Germany</i>	
	Usual Residence of Decedent				10a. State <i>Md.</i>		10b. County <i>n/a</i>		10c. City, Town or Location <i>Baltimore</i>	
To Be Completed by Funeral Director		10e. Street and Number <i>201 Warren Ave. Apt. 104</i>				10f. Zip Code <i>21230</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>+2</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Factory Worker</i>		16b. Kind of Business/Industry <i>Phillip Morris</i>				
		17. Father's Name (First, Middle, Last) <i>Michael A. Barthel</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Katharina Britz</i>				
		19a. Informant's Name/Relationship (Type, Print) <i>Cathy D. Rozankowski (Dgt.)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1730 S. Charles Street, Baltimore, Md. 21230</i>				
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Bayview Crematory</i>		Date <i>01/26/04</i>		20c. Location - City or Town, State <i>Baltimore, Md.</i>		
		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>McCully-Polyniak Funeral Home p.A. 130 E. Fort Ave. Baltimore, Md. 21230</i>						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Myocardial Infarction</i> Due to (or as a consequence of): b. <i>Hyperkalemia</i> Due to (or as a consequence of): c. <i>acute renal failure</i> Due to (or as a consequence of): d. <i>coronary artery disease</i>		Approximate Interval Between Onset and Death <i>50 minutes</i> <i>1 day</i> <i>10 days</i> <i>10 years</i>						
Physician /Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D0052032</i>		29d. Date signed (Month, Day, Year) <i>January 21, 2004</i>		
State Registrar		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Robert M. [Signature] MD 3001 South [Signature] Street, Baltimore, MD 21225</i>								
		31. Date filed (Month, Day, Year) <i>JAN 23 2004</i>		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

6827-1/23/04 tas

2004 01740

1- For State Registrar Amend Item #1&31 per dvr&phy Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth Kelley</b> <del>ELIZABETH KELLY</del>			2. Date of Death Month <b>JAN</b> Day <b>16</b> Year <b>2004</b>		3. Time of Death <b>11:30AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NIA</b>	
Funeral Director	5. Social Security Number <b>214-01-6131</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>03/02/1915</b>		9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent:						
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2106 Edmondson Ave.</b>			10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Benjamin Landrum</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Larner</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Sharon Landrum/Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2106 Edmondson Ave. Baltimore, MD 21228</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. Location - City or Town, State <b>01/20/2004 Baltimore, MD</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>PNEUMONIA</b> Due to (or as a consequence of): b. <b>PRIOR SEPTICEMIA</b> Due to (or as a consequence of): c. <b>INFERIOR VENA CAVA THROMBUS</b> Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death <b>2 weeks</b> <b>2 months</b> <b>2 months</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>15198</b>		29d. Date signed (Month, Day, Year) <b>JAN, 16, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SAPNA MAREPALLY 29 SPACA STREET BALTIMORE MD.</b>							
31. Date filed (Month, Day, Year) <b>JAN 16, 2004</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01741

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SYLVAIN KAHN</b>		2. Date of Death Month <b>JANUARY</b> Day <b>17</b> , Year <b>2004</b>		3. Time of Death <b>9:15 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>		4b. City, Town, or Location of Death <b>GAITHERSBURG</b>		4c. County of Death <b>MONTGOMERY</b>
Funeral Director	5. Social Security Number <b>432-50-6915</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>SEPT. 22, 1930</b>		9. Birthplace (State or Foreign Country) <b>GERMANY</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>GAITHERSBURG</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>404 NORTH SUMMIT AVENUE #102</b>		10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>ARMY KOREA</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINE OPERATOR</b>		16b. Kind of Business/Industry <b>EASTERN PRODUCTS</b>		
	17. Father's Name (First, Middle, Last) <b>JOSEPH KAHN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>THERESA BERMAN</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>TOBY KAHN / WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>404 NORTH SUMMIT AVENUE #102 - GAITHERSBURG, MD 20877</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD VETERANS CEMETERY</b>		20c. Location - City or Town, State <b>1/22/2004 OWINGS MILLS, MD</b>
	21. Signature of Funeral Service Licensee <i>Scott M. Cutler</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b> a. Due to (or as a consequence of): <b>ASPIRATION PNEUMONIA</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
	Approximate Interval Between Onset and Death				
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				
	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide					
28a. Date of Injury (Month, Day, Year)					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Truong Bao, MD</i>					
29c. License number <b>D0057124</b>					
29d. Date signed (Month, Day, Year) <b>1/17/04</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Truong Bao, MD, Shady Grove Adventist</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>					
32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01742

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gordon R. Kanzler</b>		2. Date of Death Month Day Year <b>January 17, 2004</b>		3. Time of Death <b>3:00 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Joseph Richey Hospice</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>214-36-3061</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Apr 21, 1939</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>524 N. Charles Street</b>		10f. Zip Code <b>21201</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>bartender</b>		16b. Kind of Business/Industry <b>beverage</b>		
	17. Father's Name (First, Middle, Last) <b>Louis Kanzler</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lucille Colbert</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Jackie Parrish/sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>300 Georgia Avenue Glen Burnie, MD 21060</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Lung Carcinoma</b>				Approximate Interval Between Onset and Death <b>1 Month</b>
	Immediate Cause (Final disease or condition resulting in death)				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	IF FEMALE:				
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <b>James X. Sun, MD</b>		29c. License number <b>344715</b>		29d. Date signed (Month, Day, Year) <b>1.17.04</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANCIS X. STRAIN, III, MD 301 ST Paul Bldg MD 21202</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHM 17 Rev 1/2001

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01743

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel Kraft

2. Date of Death

January 19, 2004

3. Time of Death

10:00P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Manor Care Rossville

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

219-07-2462

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10/1/19

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

608 Dale Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Hair

17. Father's Name (First, Middle, Last)

Jesse Curtis Bull

18. Mother's Name (First, Middle, Maiden Surname)

Edna Pearl Caltrider

19a. Informant's Name/Relationship (Type, Print)

Kathleen Sweeney (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

608 Dale Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore-Washington Crematory

1/26/04

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Elizabeth Selinski

22. Name and Address of Facility

Miller-Dippel Funeral Home, Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ENCEPHALOPATHY

Approximate Interval Between Onset and Death

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis H. Odle MD

29c. License number

D55306

29d. Date signed (Month, Day, Year)

Jan 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis H. Odle MD, 1232 Roseville, Suite 203, Rossville Home Care Bldg, MD 21237

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Dennis H. Odle

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01744

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daisy I. Lebon				2. Date of Death Month Day Year January 22, 2004		3. Time of Death 5:10 am	
	4a. Facility Name (If not institution, give street and number) Saint Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 213-18-3356		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 8, 1920	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1331 Georgetown Road		10f. Zip Code 21230		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) unk.		18. Mother's Name (First, Middle, Maiden Surname) unk.					
	19a. Informant's Name/Relationship (Type, Print) Edgar Fogler, Sr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1331 Georgetown Road Baltimore, Maryland 21230					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		20c. Location - City or Town, State Elkridge, Maryland			
	21. Signature of Funeral Service Licensee M. K. Harkman		22. Name and Address of Facility Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Stroke Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Chronic Obstructive Lung Disease Due to (or as a consequence of): d. Dementia		23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23c. Date of delivery Month Day Year		Approximate Interval Between Onset and Death days days years years	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. Date of delivery Month Day Year		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28c. Injury at Work? 28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier S. Yousef, M.D.		29c. License number D0060501		29d. Date signed (Month, Day, Year) January 22, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sahar Yousef 900 Cedar Ave Baltimore, MD 21219		31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature [Signature]				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01745

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Charles Leizear</i>				2. Date of Death Month Day Year <i>January 20 2004</i>				3. Time of Death <i>1920</i>			
	4a. Facility Name (If not institution, give street and number) <i>Sinai Hospital of Baltimore</i>				4b. City, Town, or Location of Death <i>Baltimore City</i>				4c. County of Death			
Funeral Director	5. Social Security Number <i>214-12-0640</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>81</i> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <i>Dec 15 1922</i>		9. Birthplace (State or Foreign Country) <i>Md</i>	
	Usual Residence of Decedent										10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State <i>Md</i>		10b. County <i>Carroll</i>		10c. City, Town or Location <i>Sykesville</i>							
	10e. Street and Number <i>7200 Third Avenue C-111</i>				10f. Zip Code <i>21784</i>				10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>white</i>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>executive vice president</i>				16b. Kind of Business/Industry <i>National Data Corp.</i>			
	17. Father's Name (First, Middle, Last) <i>Charles Robert Leizear</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Nellie Byer</i>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Jean S. Leizear (spouse)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7200 Third Ave., C-111, Sykesville, Md. 21784</i>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>All County Cremation</i>				Date <i>1-23-04</i>		20c. Location - City or Town, State <i>Sykesville, Md</i>	
	21. Signature of Funeral Service Licensee <i>Page Haight Herbert</i>				22. Name and Address of Facility <i>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, Md 21784</i>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) a. <i>Heart Failure</i> Due to (or as a consequence of): b. <i>Sepsis</i> Due to (or as a consequence of): c. <i>Aortic valve endocarditis</i> Due to (or as a consequence of): d. <i>Mitral valve endocarditis</i>										<i>34 days</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Alexandro Sequeira M.D.</i>				29c. License number <i>D0024726</i>		29d. Date signed (Month, Day, Year) <i>January 20 - 2004</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Alexandro Sequeira 2401 West Belvedere Avenue Baltimore Maryland 21215</i>												
31. Date filed (Month, Day, Year) <i>JAN 23 2004</i>				32. Registrar's Signature <i>[Signature]</i>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01746

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES JOHN LUYK</b>			2. Date of Death Month Day Year <b>JANUARY 14, 2004</b>		3. Time of Death <b>6:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>239 WOODHILL DR., APARTMENT B</b>			4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>381-42-2439</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/28/1942</b>	
	9. Birthplace (State or Foreign Country) <b>MICHIGAN</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State <b>MD</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>GLEN BURNIE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>239 WOODHILL DRIVE, APARTMENT B</b>			10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Budget Analyst</b>		16b. Kind of Business/Industry <b>DEPARTMENT OF DEFENCE</b>	
	17. Father's Name (First, Middle, Last) <b>JOHN JAMES LUYK</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>ALTHEA (UNKNOWN)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>KIMBERLY SHEEHAN - DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>832 WINDSOR ROAD, ARNOLD, MARYLAND 21012</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BAYVIEW CREMATORY</b>		Date <b>1/23/2004</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>
	21. Signature of Funeral Service Licensee <b>KELLY GREGORY FINK #M01148</b>		22. Name and Address of Facility <b>FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>b. DIABETES MELLITUS</b> Due to (or as a consequence of): <b>c. HYPERTENSION</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>d.</b>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CEREBRAL HEMORRHAGE</b> <b>SEIZURE DISORDER</b>					23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Dominick J. Memoli MD</b>		29c. License number <b>D41141</b>		29d. Date signed (Month, Day, Year) <b>1/22/04</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dominick J. Memoli MD 1406 S. CRAIN HIGHWAY GLEN BURNIE MD 21061</b>							
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01747

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Loris Roselle Lansey

2. Date of Death

January 17, 2004

3. Time of Death

2:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

330 Council Oak Drive

4b. City/Town, or Location of Death

Severn

4c. County of Death

N/A

5. Social Security Number

212-34-9106

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 17, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

N/A

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

330 Council Oak Drive

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ulysses Livingston

18. Mother's Name (First, Middle, Maiden Surname)

Edna Ruffin-Lewis

19a. Informant's Name/Relationship (Type, Print)

Mr. Wallis Lansey (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

330 Council Oak Drive Severn, Md. 21144

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GreenMount Crematory

Date

1/26/2004

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balt. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. small cell lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

11 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph L. Russ

29c. License number

D35254

29d. Date signed (Month, Day, Year)

1/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carol Miller 900 Catonsville Baltimore MD 21229

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01748

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH HANCE LOEFFLER			2. Date of Death Month JANUARY 10, 2004 Day Year			3. Time of Death 10:50 A M														
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death														
Funeral Director	5. Social Security Number 227-33-9532			6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 23 Yrs.		8. Date of Birth Month JANUARY Day 20 Year 1980		9. Birthplace (State or Foreign Country) NEW JERSEY											
	10a. State MD			10b. County WASHINGTON		10c. City, Town or Location SHARPSBURG			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												
To Be Completed by Funeral Director	10e. Street and Number 223 E. MAIN STREET			10f. Zip Code 21782			10g. Citizen of What Country? USA														
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RECEPTIONIST			16b. Kind of Business/Industry FINANCIAL														
	17. Father's Name (First, Middle, Last) JOHN V. LOEFFLER			18. Mother's Name (First, Middle, Maiden Surname) SUSAN PEPPER																	
	19a. Informant's Name/Relationship (Type, Print) JOHN V. LOEFFLER/FATHER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 E. MAIN STREET, SHARPSBURG, MD 21782																	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ELMWOOD CEMETERY			Date JANUARY 14, 2004			20c. Location - City or Town, State SHEPHERDSTOWN, WV											
	21. Signature of Funeral Service Licensee Charles M. Brown			22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CYSTIC FIBROSIS EXACERBATION (LUNG) Due to (or as a consequence of): b. CYSTIC FIBROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 2 MONTHS 23 YEARS														
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year														
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
Medical Certification; To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check on one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier M Boyle MD			29c. License number D46141			29d. Date signed (Month, Day, Year) 1/13/2004											
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Boyle 1830 E. Monument Street, 5th floor, Baltimore MD 21205																				
	31. Date filed (Month, Day, Year) JAN 23 2004			32. Registrar's Signature [Signature]																	
	State Registrar																				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01719

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte Joan Marshall

2. Date of Death

Jan. 20, 2004

3. Time of Death

7:33 PM<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

1627 Spence Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral Director

5. Social Security Number

215-76-1636

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Apr. 19, 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1627 Spence Street

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Fairfield Inn

17. Father's Name (First, Middle, Last)

James Richard Curtin

18. Mother's Name (First, Middle, Maiden Surname)

Mable Irene Coburn

19a. Informant's Name/Relationship (Type, Print)

David R. Marshall, Sr. - Spouse 1627 Spence Street Baltimore, Maryland 21230

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

1/24/04

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

M. Pgh

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.  
7250 Washington Blvd., Elkridge, MD 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lung cancer  
Due to (or as a consequence of):

16 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

L. Austin Doyle, M.D.

29c. License number

D23809

29d. Date signed (Month, Day, Year)

1/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Austin Doyle, M.D., Greenbaum Cancer Ctr., 22 S. Greene St., Balt., MD 21201

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01750

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Cherry Miller</b>			2. Date of Death Month <b>Jan</b> Day <b>22</b> Year <b>2004</b>		3. Time of Death <b>1:50a<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>Upper Chesapeake Hospital</b>			4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>212-60-4581</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>54</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 7 1949</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Harford</b>	10c. City, Town or Location <b>Joppa</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>351 Ellsworth Place</b>			10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>		16b. Kind of Business/Industry <b>Amusement Business</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Hubert F. Murray</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Smith</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Hubert Murray/brother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>909 Averill Road Joppa Md 21085</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HollyHillCemetery</b>		Date <b>1/24/04</b>		20c. Location - City or Town, State <b>Baltimore MD</b>
	21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>		22. Name and Address of Facility <b>ConnellyFuneralHomeofEssex</b> <b>300 Mace Ave. Baltimore MD 21221</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Bacterial Endocarditis</b> Due to (or as a consequence of): <b>Bacterial Meningitis</b> Due to (or as a consequence of): <b>Renal Failure</b> Due to (or as a consequence of):						
	Approximate Interval Between Onset and Death <b>22 days</b> <b>22 days</b> <b>5 years</b>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						
Medical Certification; To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
State Registrar	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined						
State Registrar	28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier <b>Sherif H. Osman MD</b>		29c. License number <b>D0036715</b>		29d. Date signed (Month, Day, Year) <b>1/22/04</b>		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sherif H. Osman, M.D. 520 Upper Chesapeake Drive, Bel Air, M.D. 21014</b>						
	31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01751

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Jasper Manley</b>		2. Date of Death Month <b>1</b> Day <b>7</b> Year <b>2004</b>		3. Time of Death <b>2328 M</b>									
4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>		4b. City, Town, or Location of Death <b>Balto.</b>		4c. County of Death <b>N/A</b>									
5. Social Security Number <b>240-38-4479</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>9-1-1929</b>	9. Birthplace (State or Foreign Country) <b>N.C.</b>									
Usual Residence of Decedent													
10a. State <b>Md</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
10e. Street and Number <b>3019 Rosalind Avenue</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U S A</b>									
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:									
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unk</b> College (1-4or 5+) <b>Unk</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Masonry</b>		16b. Kind of Business/Industry <b>Brick Cleaning</b>									
17. Father's Name (First, Middle, Last) <b>Roosevelt Manley</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Reather Lynch</b>										
19a. Informant's Name/Relationship (Type, Print) <b>Geraldine Staton - Sister</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1402 Stonewood Road Balto, Md 21239</b>										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt Zion Cemetery</b>		20c. Location - City or Town, State <b>1-13-2004 Lansdown, Md</b>									
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Avenue Balto, Md 21215</b>											
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Asthma</b>													
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
<table border="0"> <tr> <td>a. Due to (or as a consequence of):</td> <td><b>Rheumatoid Arthritis</b></td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> <td><b>Hypertension</b></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table>						a. Due to (or as a consequence of):	<b>Rheumatoid Arthritis</b>	b. Due to (or as a consequence of):	<b>Hypertension</b>	c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
a. Due to (or as a consequence of):	<b>Rheumatoid Arthritis</b>												
b. Due to (or as a consequence of):	<b>Hypertension</b>												
c. Due to (or as a consequence of):													
d. Due to (or as a consequence of):													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>									
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <i>[Signature]</i> <b>M.D.</b>		29c. License number <b>D46305</b>		29d. Date signed (Month, Day, Year) <b>1/14/04</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANURADHA REDDY M.D.</b> <b>821 N. Euteraw Street Suite # 312, Baltimore MD 21201</b>													
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <i>[Signature]</i>											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01752

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Ruby J. McCall</b>		2. Date of Death Month <b>1</b> Day <b>19</b> Year <b>2004</b>		3. Time of Death <b>2245</b> M	
4a. Facility Name (If not institution, give street and number) <b>J.H.H. Bayview Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Md.</b>	
5. Social Security Number <b>210-34-1609</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10-20-42</b>
9. Birthplace (State or Foreign Country) <b>Md.</b>		Usual Residence of Decedent			
10a. State <b>Md.</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>5520 Frankford Ave.</b>		10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>4 yrs</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dept. Of Human Resources</b>		16b. Kind of Business/Industry <b>State of Md</b>			
17. Father's Name (First, Middle, Last) <b>Booker T. Faulcon</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jerldene Wilkins</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Niccole McCall Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5520 Frankford Ave., Baltimore, Md. 21202</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cem.</b>		20c. Location - City or Town, State <b>1-23-04 Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Md. 21202</b> <b>March F.H. East 1101 E. North Ave.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Atherosclerotic Cardiovascular disease</b> Due to (or as a consequence of): <b>b. IDDM</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>					
Approximate Interval Between Onset and Death <b>1 year</b> <b>3 years</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HIV disease</b> <b>Chronic Renal Failure</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D28987</b>		29d. Date signed (Month, Day, Year) <b>1/21/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CARL SPERLING, M.D. 5601 LOCH RAVEN BLVD BALTO. MD 21239</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2004 01753

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN MERRITT

2. Date of Death

JAN. 18, 2004

3. Time of Death

3:00 P.M.

4a. Facility Name (If not institution, give street and number)

3411 DILLON ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-22-4640

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 17, 1927

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State  
MD.10b. County  
N/A10c. City, Town or Location  
BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3411 DILLON ST.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BETH STEEL

16b. Kind of Business/Industry

LABORER

17. Father's Name (First, Middle, Last)

HENRY C. MERRITT

18. Mother's Name (First, Middle, Maiden Surname)

FLURY

19a. Informant's Name/Relationship (Type, Print)

GEORGE K. NASSNER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3409 ORLANDO AVE BALTO, MD. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLLY HILL CEM.

Date

JAN 21 2004

20c. Location - City or Town, State

BALTO, MD.

21. Signature of Funeral Service licensee

Thomas J. Skarda Jr.

22. Name and Address of Facility

HOFFMAN-SKARDA 3218 HUDSON ST BALTO, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Approximate Interval Between Onset and Death

20

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

E. F. Quinn Jr.

29c. License number

D 38033

29d. Date signed (Month, Day, Year)

1/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

New BSM 2615 Highland Ave (Balt. City) 21224

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 01754  
 1- Amend Item 1 per Dr. G827, 01/23/04 dnb Certificate of Death Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James P. Matthews Sr.</b>			2. Date of Death Month <b>01</b> Day <b>12</b> Year <b>04</b>			3. Time of Death <b>5:45 AM</b>				
	4a. Facility Name (If not institution, give street and number) <b>3818 Harlem Ave. Baltimore</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>Baltimore</b>				
Funeral Director	5. Social Security Number <b>318078281</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>07/12/17</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>3818 Harlem Avenue</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th GRADE</b> College (1-4or 5+) <b>6 yrs</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Principal</b>			16b. Kind of Business/Industry <b>Balto. City Schools</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Samuel L. Matthews</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ella O'Neill</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>James P. Matthews Jr. (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2518 Harlem Ave, Baltimore, MD 21216</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>		Date <b>01-16-04</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>				
	21. Signature of Funeral Service Licensee <b>Vaughn C. Sh...</b>		22. Name and Address of Facility <b>Vaughn C. Greene Funeral Service 515 Balto. Nat'l Pike, Balto. MD 21229</b>								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Coronary Artery Disease</b> Due to (or as a consequence of): b. <b>Diabetes Mellitus Type II</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
State Registrar	29b. Signature and title of certifier <b>McNeal Brockington III MD</b>				29c. License number <b>D35984</b>		29d. Date signed (Month, Day, Year) <b>01/13/04</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>McNeal Brockington III, MD 6609 REISTERSTOWN RD. #104 BALTIMORE, MD. 21215</b>										
31. Date filed (Month, Day, Year) <b>JAN 14 2004</b>		32. Registrar's Signature <b>[Signature]</b>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01755

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VANITY MAXEY</b>						2. Date of Death Month <b>JAN</b> Day <b>16</b> Year <b>2004</b>		3. Time of Death <b>1225 P</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GEN HOSP</b>						4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>	
Funeral Director	5. Social Security Number <b>243-40-6896</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>09/12/1927</b>		9. Birthplace (State or Foreign Country) <b>N.C.</b>	
	Usual Residence of Decedent									
10a. State <b>MD.</b>			10b. County <b>Howard</b>			10c. City, Town or Location <b>Columbia</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>9121 Gracious End Ct. #104</b>						10f. Zip Code <b>21046</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>John Jasper Goode</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Georgiana Gordon</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Antoinette Dickson/daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12321 Lisborough Road, Bowie, Md. 20720</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calverton Veterans Cemetery</b>			20c. Location - City or Town, State <b>01/23/04 Calverton, N.Y</b>	
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, Md. 21045</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>RESPIRATORY FAILURE</b> Approximate Interval Between Onset and Death <b>5 Days</b>										
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PNEUMONIA</b> Approximate Interval Between Onset and Death <b>5 Days</b>										
23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE MYOCARDIAL INFARCTION</b>										
23d. Date of delivery Month Day Year										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day Year)										
28b. Time of Injury <b>M</b>										
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>ASYMD</b>										
29c. License number <b>D39629</b>										
29d. Date signed (Month, Day, Year) <b>JAN 16, 2004</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ASYMD 10724 LITTLE PATUXENT BLVD COLUMBIA MD 21044</b>										
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>										
32. Registrar's Signature 										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01756

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Charles Nichols</i>		2. Date of Death Month <i>January</i> Day <i>13</i> Year <i>2004</i>		3. Time of Death <i>16:28</i> M	
4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical System</i>		4b. City, Town, or Location of Death <i>Baltimore, Maryland</i>		4c. County of Death	
5. Social Security Number <i>215-22-6833</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>77</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>November 30, 1926</i>
9. Birthplace (State or Foreign Country) <i>Maryland</i>					
Usual Residence of Decedent					
10a. State <i>MD</i>	10b. County <i>Harford</i>	10c. City, Town or Location <i>Havre de Grace</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>902 Lapidum Rd.</i>		10f. Zip Code <i>21078</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-46</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Heavy Equipment Mechanic</i>		16b. Kind of Business/Industry <i>U.S. Government</i>	
17. Father's Name (First, Middle, Last) <i>William Nichols</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Marie Edwards</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Linda Nichols- Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1317 Aiken Ave. Ext., Perryville, MD 21903</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Harford Mem. Grdns.</i>		20c. Location - City or Town, State <i>01/17/04 Aberdeen, MD</i>	
21. Signature of Funeral Service Licensee <i>Deanne M. Smith</i>		22. Name and Address of Facility <i>Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Acute Intestinal Pneumonitis</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death <i>2 months</i>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Brian Kelly MD</i>		29c. License number <i>#15261</i>		29d. Date signed (Month, Day, Year) <i>January 13, 2004</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Brian Kelly, 225 Greene St, Baltimore MD, 21201</i>					
31. Date filed (Month, Day, Year) <i>JAN 23 2004</i>		32. Registrar's Signature <i>[Signature]</i>			

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01757

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Geraldine E. Newsome</b>		2. Date of Death Month <b>01</b> Day <b>21</b> Year <b>2004</b>		3. Time of Death <b>1134</b> M	
4a. Facility Name (If not institution, give street and number) <b>3101 Chelsea Terr</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore City</b>	
5. Social Security Number <b>231-44-5958</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>5/01/1938</b>	9. Birthplace (State or Foreign Country) <b>VA</b>	
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3101 Chelsea Terrace</b>		10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Social Worker</b>		16b. Kind of Business/Industry <b>State of MD -Dept. of Social Services</b>	
17. Father's Name (First, Middle, Last) <b>Girney Babb</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Pearlie Warren</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Rebecca Shante' Childers- Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3101 Chelsea Terrace Balto., MD 21216</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		20c. Location - City or Town, State <b>Balto., MD</b>	
21. Signature of Funeral Service Licensee <b>Branford</b>		22. Name and Address of Facility <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto., MD 21216</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Breast Cancer</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>					Approximate Interval Between Onset and Death <b>4/22/2004</b>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <b>Katherine Tkacuk</b>		29c. License number <b>D36146</b>		29d. Date signed (Month, Day, Year) <b>1/22/2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KATHERINE TKACUK 225 Greene St Baltimore MD 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>B Sparks</b>			



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01758

1- For State Registrar AMEND ITEM #28F PER ME G827 1/23/04 Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Chad</b>		2. Date of Death Month <b>January</b> Day <b>21</b> Year <b>2004</b>		3. Time of Death <b>3:44 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>	
5. Social Security Number <b>373-78-2294</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>31</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Mar 27, 1972</b>	9. Birthplace (State or Foreign Country) <b>Michigan</b>	
Usual Residence of Decedent					
10a. State <b>Md.</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Dundalk</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>6600 Woods Parkway Apt. 2B</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Porter</b>		16b. Kind of Business/Industry <b>Hotel</b>			
17. Father's Name (First, Middle, Last) <b>Michael Lee Neuman</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Judith Jane VanSingel</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Judith J. Brown</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19133 Dowden Circle Poolesville, Md 20837</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		20c. Location - City or Town, State <b>1/23/2004 Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md 21222</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Traumatic Brain Injury</b>		23b. Due to (or as a consequence of): <b>Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>Hours</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>January 20, 2004</b>		28b. Time of Injury <b>4:12 PM</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>pedestrian struck by jeep</b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28f. Location (Street and Number or Rural Route Number) <b>DUNDALK AVE AND WILLOW SPRING RD Dundalk, Md</b>			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>RES-000</b>	
29d. Date signed (Month, Day, Year) <b>January 21, 2004</b>		29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joni Vogel 4940 Eastern Avenue, Baltimore, Maryland 21224</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joni Vogel 4940 Eastern Avenue, Baltimore, Maryland 21224</b>		31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>			
32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01759

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Keith Oakley				2. Date of Death Month Day Year January 17 2004		3. Time of Death 8 P M		
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 059-16-5060	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 7, 1919		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore City			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 1309 Northview Road			10f. Zip Code 21218		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant		16b. Kind of Business/Industry Accounting				
	17. Father's Name (First, Middle, Last) Roy Oakley				18. Mother's Name (First, Middle, Maiden Surname) Alta Parker				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Scott Oakley- son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 Northview Road Baltimore, Maryland 21218				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Balt./Wash. Crematory		20c. Location - City or Town, State Laurel, Maryland		20d. Date 1/22/2004		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore, Maryland 21206						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypovolemia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 14 Hours								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number AU4176435-N13114		29d. Date signed (Month, Day, Year) January 17 2004			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218									
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature 							

2+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01760

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen PECK

2. Date of Death

Month

Day

Year

3. Time of Death

January

20

2004

11:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Joseph's Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

300-12-9442

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

Jan 22, 1925

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1222 Tugwell Drive

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Jewelry

17. Father's Name (First, Middle, Last)

Joseph Zaborowski

18. Mother's Name (First, Middle, Maiden Surname)

Mary Osika

19a. Informant's Name/Relationship (Type, Print)

Dr. Robert J. Telepak MD/Nephew 875 Calle De Bosque, Bosque Farms, NM 80768

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

Jan 22

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

S. Hahel 100984

22. Name and Address of Facility

Cremation and Funeral Alternatives  
8717 Green Pastures Drive Baltimore, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA of the Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Brain Metastasis

Due to (or as a consequence of):

Three Months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

N. B. Kellanki

29c. License number

D. 30469

29d. Date signed (Month, Day, Year)

January 21, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. B. KELLANKI, 9055 CHEVROLET DRIVE, #100, ELLICOTT CITY, MD 21042

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01761

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Mae Pratt

2. Date of Death

01-21-2004

3. Time of Death

9:30 PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-05-4442

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 25, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2211 W. Rogers Avenue

10f. Zip Code

21209

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Alice Sadler

19a. Informant's Name/Relationship (Type, Print)

Mrs. Ella Jourdan / Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

53 Old Zion Road North East, Maryland 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

Jan. 24, 2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael E. Canapp

22. Name and Address of Facility

5305 Harford Road  
Leonard J. Ruck, Inc. Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE CARDIAC DYSRHYTHMIA

Approximate Interval Between Onset and Death

ACUTE

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

DAYS

Due to (or as a consequence of):

c. HYPERTENSIVE CARDIOVASCULAR DISEASE

YEARS

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RECENT GASTROINTESTINAL BLEED

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert E. Roby, M.D.

29c. License number

D-19425

29d. Date signed (Month, Day, Year)

1/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT E. ROBY, M.D. - 2211 W. ROGERS AVE - BALTO, MD 21209

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

John A. Spade

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #1 PER PHY G828 2/05/04 Certificate of Death

Reg. No.

2004 01762

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <u>MARY PETTIFORD</u>		2. Date of Death Month <u>JAN</u> Day <u>19</u> Year <u>2004</u>		3. Time of Death <u>8:15 AM</u>	
4a. Facility Name (If not institution, give street and number) <u>Rolling Manor</u>		4b. City, Town, or Location of Death <u>Pikesville</u>		4c. County of Death <u>BALTIMORE</u>	
5. Social Security Number <u>370-22-8843</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>85</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>4-11-18</u>	9. Birthplace (State or Foreign Country) <u>IN</u>	
Usual Residence of Decedent					
10a. State <u>MD</u>	10b. County <u>Baltimore</u>	10c. City, Town or Location <u>Pikesville</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <u>8813 Stoneridge Circle</u>		10f. Zip Code <u>21208</u>		10g. Citizen of What Country? <u>USA</u>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12<sup>th</sup></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Domestic</u>		16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) <u>Harold Pettiford</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Rilla Ventures</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Melva J. McKenzie Daughter</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8813 Stoneridge Circle Pikesville, MD 21208</u>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Loudon Park</u>		20c. Location - City or Town, State <u>1-26-04 Baltimore MD</u>	
21. Signature of Funeral Service Licensee <u>Vaughn C. Greene</u>		22. Name and Address of Facility <u>Vaughn C. Greene Funeral Services 8728 Liberty Rd Randallstown, MD 21123</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>End Stage Renal Disease</u> Due to (or as a consequence of): b. <u>Coronary Artery Disease</u> Due to (or as a consequence of): c. <u>Hypertension</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>Vaughn C. Greene</u>		29c. License number <u>029085</u>		29d. Date signed (Month, Day, Year) <u>JAN 22 2004</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Allen J. Ch... 5310 Old Court Road 21133</u>					
31. Date filed (Month, Day, Year) <u>JAN 23 2004</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01763

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>A.K.A. WALTER T. PACHULSKI</b> <b>WALTER T. PACHOLSKI</b>				2. Date of Death Month <b>January</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>1:19 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rose Dale</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-16-3746</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>9/5/17</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>DUNDALK</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>7922 DIEHLWOOD ROAD</b>		10f. Zip Code <b>21222</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+) <b>0</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TUG BOAT ENGINEER</b>				16b. Kind of Business/Industry <b>TUG BOAT</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>VINCENT PACHOLSKI</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA JANKIEWICZ</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MRS. HELEN G. PACHOLSKI</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7922 DIEHLWOOD RD. BALTIMORE, MD. 21222</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HOLY ROSARY CEME.</b>		20c. Location - City or Town, State <b>DUNDALK, MD.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>KACZOROWSKI FUNERAL HOME P.A.</b> <b>1201 DUNDALK AVE. BALTIMORE, MD. 21222</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Pneumonia</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>2 1/2 weeks</b>			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
	29c. License number <b>SC057573</b>				29d. Date signed (Month, Day, Year) <b>1/20/04</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Krysten Fairbanks 9000 Franklin Square Drive Baltimore, MD. 21237</b>				31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>			
	32. Registrar's Signature 				33. Registrar's Title <b>Registrar</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01764

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Romel Pittman</b>		2. Date of Death Month Day Year <b>January 15, 2004</b>		3. Time of Death <b>10:13 P<sup>M</sup></b>
	4a. Facility Name (If not institution, give street and number) <b>2402 East Eager Street</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>
Funeral Director	5. Social Security Number <b>215-78-3985</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>30</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>12-6-73</b>	
	9. Birthplace (State or Foreign Country) <b>Md.</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Md.</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>2330 E. Eager Street</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Mason</b>
	17. Father's Name (First, Middle, Last) <b>Sidney White, Jr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Yvette Pittman</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Yvette Pittman Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2732 Fenwick Ave., Baltimore, Md. 21218</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk.</b>		20c. Location - City or Town, State <b>1-24-04 Arbutus ,Md.</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Md. 21202</b> <b>March F.H. East 1101 E. North Ave.</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple gunshot wounds</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown
	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>At scene</b>		
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>January 15, 2004</b>		28b. Time of Injury <b>10:06 P<sup>M</sup></b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject was shot</b>		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2402 E. Eager St, Baltimore MD</b>		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>Tasha Z Greenberg MD</b>		
29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>January 16, 2004</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Tasha Z Greenberg M.D. 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01765

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Grace Miller Phipps

2. Date of Death  
Month Day Year

January 21, 2004

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

1939 Glen Cove Road

4b. City, Town, or Location of Death

Darlington

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

213-78-0819

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Aug. 26, 1913

9. Birthplace (State or Foreign  
Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Darlington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1939 Glen Cove Road

10f. Zip Code

21034

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Christian A. Karr

18. Mother's Name (First, Middle, Maiden Surname)

Elma Nookumer Miller

19a. Informant's Name/Relationship (Type, Print)

Marie Olinger / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1939 Glen Cove Road, Darlington, Maryland 21034

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Darlington Cemetery

Date

1-31-04

20c. Location - City or Town, State

Darlington, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. endstage dementias  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):c. Due to (or as a consequence of):d. Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID S. DUNN 615 W. MacPhail Rd. Bel Air MD

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

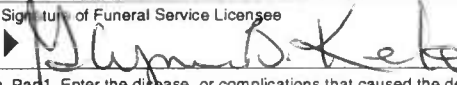

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01766

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Martha N. Robinson</b>			2. Date of Death Month <b>1</b> Day <b>16</b> Year <b>2004</b>		3. Time of Death <b>11:27 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Villa St Michael</b>			4b. City, Town, or Location of Death <b>Balto</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>256-46-0746</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>12-17-1929</b>		9. Birthplace (State or Foreign Country) <b>Ga</b>	
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Md</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Balto</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>10 Mount Batten Ct</b>			10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U S A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b>		College (1-4or 5+) <b>2 Years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self Employed</b>		16b. Kind of Business/Industry <b>Cosmetologist</b>
	17. Father's Name (First, Middle, Last) <b>Len Ramsey</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Willie Mae Sullivan</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Alvin Robinson, Jr - Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5709 E. Moenwald Oaks Drive Acworth, Ga 30102</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		Date <b>1/22/2004</b>		20c. Location - City or Town, State <b>Balto, Md</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Avenue Balto, MD 21215</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Senile Dementia</b> Due to (or as a consequence of): <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>						
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 23d. Date of delivery Month <b>1</b> Day <b>21</b> Year <b>04</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 			29c. License number <b>255425</b>		29d. Date signed (Month, Day, Year) <b>1/21/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Willie B. MUEHL 413 Commonwealth AV COLLETSVILLE, MD 21228</b>							
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01767

Certificate of Death

Reg. No.

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) LLOYD DWIGHT RINGER		2. Date of Death Month: January Day: 13 Year: 2004		3. Time of Death 7:30 AM
	4a. Facility Name (If not institution, give street and number) Franklin square hospital		4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 232-56-6956	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 69 Yrs.	8. Date of Birth (Month, Day, Year) 7/9/1934	9. Birthplace (State or Foreign Country) WEST VIRGINIA
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 910 KINWAT AVENUE		10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PLUMBING FOREMAN		16b. Kind of Business/Industry SOCIAL SECURITY ADMIN.		
	17. Father's Name (First, Middle, Last) FRANK ERNEST RINGER		18. Mother's Name (First, Middle, Maiden Surname) LULA G. RODEHEAVER		
	19a. Informant's Name/Relationship (Type, Print) NAOMI RINGER - WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 KINWAT AVENUE, BALTIMORE, MARYLAND 21221		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SHADY GROVE CEMETERY		20c. Location - City or Town, State BRUCETON MILLS, WV
21. Signature of Funeral Service Licensee KELLY GREGORY FINK #M01148		22. Name and Address of Facility MARYLAND MORTUARY/ FINK FH PA 426 CRAIN HIGHWAY SOUTH, GLEN BURNIE, MD 21061			
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Advanced mantle cell Lymphoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
	Approximate Interval Between Onset and Death 8 months				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				
	23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure Abdominal Abscess					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 29c. License number D 57721 29d. Date signed (Month, Day, Year) 1/15/04					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Laura Steele 9000 Franklin Square Drive Baltimore MD, 21237					
31. Date filed (Month, Day, Year) JAN 23 2004 32. Registrar's Signature					

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01768

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

WILLIAM RUANE

2. Date of Death

Month Day Year

JAN 19 2004

3. Time of Death

4:00 PM

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

217-26-9597

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6/30/1930

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1651 E. BELVEDERE AVENUE APT. 422

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates

KOREAN

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DRAFTSMAN

16b. Kind of Business/Industry

APL

17. Father's Name (First, Middle, Last)

WILLIAM A. RUANE, SR.

18. Mother's Name (First, Middle, Maiden Surname)

CLEMENTINE UNAVAILABLE

19a. Informant's Name/Relationship (Type, Print)

DONNA MORRISON

DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9837 CAMPBELL ROAD KENSINGTON, MD 20895

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

1/21/2004

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

M. Neal Coleman

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☐ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23a. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined☐ Could not be determined☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey Pilling MD

29c. License number

D53722

29d. Date signed (Month, Day, Year)

Jan 19 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Pilling, MD

GOOD SAMARITAN HOSPITAL BALTIMORE MD

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01769

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MATILDA ALICE ROBINSON

2. Date of Death

January 20 2004

3. Time of Death

3:41 AM

4a. Facility Name (If not institution, give street and number)

Good Samaritan

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-14-3689

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

1/3/1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8607 OAK ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7TH GRADE

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

DONALD H. CUNNINGHAM

18. Mother's Name (First, Middle, Maiden Surname)

MATILDA WOPMAN

19a. Informant's Name/Relationship (Type, Print)

LINDA BARKER

DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8607 OAK ROAD BALTIMORE, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY, INC. 1/24/2004 CATONSVILLE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Heather V. Hays

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Edward Serdeland

29c. License number

D38956

29d. Date signed (Month, Day, Year)

January 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward Serdeland 5601 Loch Raven, Baltimore, Maryland

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01770

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ARTURO CASTILLO RODRIGUEZ</b>				2. Date of Death Month Day Year <b>JAN. 19 2004</b>				3. Time of Death A M <b>2:45</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOSEPH RICHIE Hospice</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>NONE</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth Month Day Year <b>APR. 13, 1943</b>		9. Birthplace (State or Foreign Country) <b>MEXICO</b>	
	Usual Residence of Decedent									
10a. State <b>W. VA</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>RANSON</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>318 E. 5TH AVE</b>				10f. Zip Code <b>25438</b>				10g. Citizen of What Country? <b>MEXICAN</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>MEXICAN</b>				14. Race - American Indian, Black, White, etc. Specify: <b>MESITZO</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>RACE HORSE TRAINER</b>				16b. Kind of Business/Industry <b>HORSES</b>		
17. Father's Name (First, Middle, Last) <b>ANTONIO CASTILLO</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ALEJANDRA RODRIGUEZ</b>						
19a. Informant's Name/Relationship (Type, Print) <b>ERNESTO CASTILLO</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1546 W. FILLMORE PHOENIX AR. 85007</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BAVVIEW CREM.</b>		Date <b>JAN. 22 2004</b>		20c. Location - City or Town, State <b>BALTO. MD.</b>				
21. Signature of Funeral Service Licensee <b>Thomas J. Spade Jr.</b>				22. Name and Address of Facility <b>SKARDA F.H. BALTO, MD. 21234</b>						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Non-small type Carcinoma @ middle lobe lung with bone metastases</b> Due to (or as a consequence of): <b>@ Remnant of TS metastases</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death <b>6 months</b>										
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown										
23d. Date of delivery Month Day Year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus, type 2</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Has p.c.</b>								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>8824 Winands Road Randallstown, MD 21133</b>								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Dr. B. J. Spade, M.D.</b>				29c. License number <b>0002175</b>		29d. Date signed (Month, Day, Year) <b>1-19-04</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROLF B. FENN 8824 Winands Road Randallstown, MD 21133</b>										
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>				32. Registrar's Signature <b>John B. Spade</b>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 905-632-0053.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01771

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Agatha Ann Rider

2. Date of Death

Jan. 18 2004 11:45 P

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Morningside Assisted Living

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

212-18-5499

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

8. Date of Birth (Month, Day, Year)

05/13/1919

9. Birthplace (State or Foreign Country)

N.Y.

Usual Residence of Decedent

10a. State

Md

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5330 Dorsey Hall Drive

10f. Zip Code

21042

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bio-chemist

16b. Kind of Business/Industry

John's Hopkins School of Public Health

17. Father's Name (First, Middle, Last)

Gottlieb Siegenthaler

18. Mother's Name (First, Middle, Maiden Surname)

Agatha LeBlanc

19a. Informant's Name/Relationship (Type, Print)

Lou Chestnutt/POA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10001 Windstream Drive #1003, Columbia, Md. 21044

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Balto/Wash. Crematory

Date

01/23/2004

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.  
5555 Twin Knolls Rd. Columbia, Md. 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Alzheimer's Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week.

5 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) ASSISTED LIVING FACILITY

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Flowers, MD

29c. License number

D20789

29d. Date signed (Month, Day, Year)

January 21, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Flowers, MD 11055 LITTLE PATUXENT PARKWAY Columbia MD

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01772

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Sheron

Russell

2. Date of Death

January 15 2004

Day

Year

3. Time of Death

8:28P

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

218-76-1603

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

37

Yrs.

8. Date of Birth

If Under 1 Year

If Under 24 Hrs.

Months

Days

Hours

Min.

9. Birthplace (State or Foreign Country)

July 31, 1966

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

2635 Ashland Ave.

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

2 Married

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Security Officer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Theodore Ward Matthews

18. Mother's Name (First, Middle, Maiden Surname)

Shirley Fulcher

19a. Informant's Name/Relationship (Type, Print)

Mrs. Shirley Randolph

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4015 Norfolk Ave. Balto. Md. 21216

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

2 Cremation

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home

2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

12 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

5 Pending investigation

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric Schmidt MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC SCHMIDT MD JOHNS HOPKINS HOSP. 600 NORTH WOLFE STREET BALTIMORE MARYLAND 21287

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Benjamin S. Spaul

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01773

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Helen H. SEZRUBA</b>				2. Date of Death Month <b>January</b> Day <b>22</b> Year <b>2004</b>		3. Time of Death <b>5:45 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN NURSING CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>184-16-4645</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11/15/1921</b>	
9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PARKVILLE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8621 CHESTNUT OAK ROAD</b>		10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OPERATIONS MANAGER</b>		16b. Kind of Business/Industry <b>WJZ</b>		17. Father's Name (First, Middle, Last) <b>JOSEPH HOYAS</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN MATSEY</b>		19a. Informant's Name/Relationship (Type, Print) <b>JANE ADAMS SISTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6705 SOUTH RIVER DR. BALTIMORE, MD 21220</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MORELAND MEM. PARK</b>		20c. Date <b>1/27/04</b>		20d. Location - City or Town, State <b>HILLENDALE, MD</b>		21. Signature of Funeral Service Licensee <b>Heath N. Hay</b>	
22. Name and Address of Facility <b>THE JOHNSON FUNERAL HOME, P.A.</b>		22. Name and Address of Facility <b>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>		23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <b>Metastatic Cancer of Breast</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>2 months</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier <b>Heath N. Hay</b>		29c. License number <b>D 30661</b>		29d. Date signed (Month, Day, Year) <b>January 22, 2004</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>5601 Loch Raven Blvd, Baltimore, Md - 21239.</b>	
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>		33. State Registrar <b>[Signature]</b>		34. State Registrar <b>[Signature]</b>	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01774

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Lou Stout

2. Date of Death

Month Day Year  
Jan. 13 20043. Time of Death  
19:16 MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

234-32-3885

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11/22/1921

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

944 Chesapeake Drive

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

Charles R. Harrison

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Morgan

19a. Informant's Name/Relationship (Type, Print)

Oliver Stout- Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

944 Chesapeake Dr., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

R.A. Ferris &amp; Co.

Date

01/20/04

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

*Duane M. Smith*

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.

123 S. Washington, Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Brandon W*

29c. License number

042800

29d. Date signed (Month, Day, Year)

1/14/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Z. Bironoo 319 S. Union Ave H&amp;G, Md. 21078

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

*James B. Smith*State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01775

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

VIRGINIA M. SHANNAHAN

2. Date of Death

January 20, 2004 3:05 a.m.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

213-01-6406

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 13, 1920 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8820 Walther Blvd. Apt. 3417

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10 yrs.College (1-4 or 5+)  
N/A16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Housekeeping-Own Home

17. Father's Name (First, Middle, Last)

John Weitzel

18. Mother's Name (First, Middle, Maiden Surname)

Mable Weitzel

19a. Informant's Name/Relationship (Type, Print)

Larry S. Shannahan (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4B12 Water Park Drive Belcamp, Md. 21017

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parkwood Cemetery

Date

1-23-2004

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Lassahn Funeral Home

22. Name and Address of Facility

7401 Belair Rd. Baltimore, Md. 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

MI

a. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

RES 00000

29c. License number

29d. Date signed (Month, Day, Year)

1/20/04

30. Name and address of person who completed cause of death (Item 22a) (Type, Print)

Dr. Eid Almatary, 9000 Franklin Square Drive, Baltimore, MD 21237

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Shannahan, Virginia

State  
RegistrarShannahan, Virginia  
Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, a Medical Examiner must be notified at  
905a.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01776

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Ann Sanders		2. Date of Death Month Day Year January 21 2004		3. Time of Death 3:54 PM
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA
Funeral Director	5. Social Security Number 219-52-3018	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	8. Date of Birth (Month, Day, Year) 2-21-49	9. Birthplace (State or Foreign Country) Md.
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Md.	10b. County NA	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 824 N. Broadway		10f. Zip Code 21205		10g. Citizen of What Country? USA
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Blue Cross Blue Shield		
	17. Father's Name (First, Middle, Last) John H. Thomas		18. Mother's Name (First, Middle, Maiden Surname) Annie E. Booker		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Annie Brown Sister-in-law		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 E. 26th Street, Baltimore, Md. 21218		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cem.		20c. Location - City or Town, State Lansdowne, Md.
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave.		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEVERE SEPSIS Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. CLOSTRIDIUM DIFFICILE COLITIS Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 10 DAYS				
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACQUIRED IMMUNODEFICIENCY SYNDROME CHRONIC LIVER DISEASE				
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier EDEM NYOMATOR, MD		29c. License number RES 000		29d. Date signed (Month, Day, Year) JANUARY 21, 2004
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDEM NYOMATOR GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BOULEVARD, MD 21236				
	31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01777

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James Milton Shimel Sr

2. Date of Death

Month Day Year  
January 11, 2004

3. Time of Death

4:15 PM M

4a. Facility Name (If not institution, give street and number)

1904 Chipper Drive

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

5. Social Security Number

215-30-4798

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 10, 1935

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1904 Chipper Drive

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

meat cutter

16b. Kind of Business/Industry

Giant Food

17. Father's Name (First, Middle, Last)

John Clifford Shimel

18. Mother's Name (First, Middle, Maiden Surname)

Lulu Anneabell Maines

19a. Informant's Name/Relationship (Type, Print)

Barbara Shimel/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1904 Chipper Drive Edgewood, MD 21040

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Renal Cell Carcinoma having mets to lungs  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

8-10 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. HX of COPD on 2R  
Due to (or as a consequence of):c. HTN  
Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown  
3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced COPD

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Home Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)  
NA28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Moham J. L. Law MD

29c. License number

D057061

29d. Date signed (Month, Day, Year)

01/13/04 (01/13/04)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMMAD M. RANA MD 4920 CAMPBELL BLVD, BALTIMORE, MD 21236

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01778

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>William Brady Smith, Jr.</b>		2. Date of Death Month <b>JANUARY</b> Day <b>19</b> Year <b>2004</b>		3. Time of Death <b>11:05A</b>	
4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>413-54-1435</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 11, 1934</b>
9. Birthplace (State or Foreign Country) <b>Tennessee</b>		Usual Residence of Decedent			
10a. State <b>Maryland</b>	10b. County <b>Harford</b>	10c. City, Town or Location <b>Darlington</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1621 Castleton Road</b>		10f. Zip Code <b>21034</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>State Highway</b>			
17. Father's Name (First, Middle, Last) <b>William Brady Smith, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lora Bell Perry</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Arlene A. Smith / Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1621 Castleton Rd., Darlington, MD 21034</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Grdns 1-23-04</b>		20c. Location - City or Town, State <b>Aberdeen, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>DAYS</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. <b>VENTRICULAR ARRHYTHMIA</b> Due to (or as a consequence of):</p> <p>b. <b>CARDIOGENIC SHOCK</b> Due to (or as a consequence of):</p> <p>c. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):</p> <p>d. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):</p>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<b>RESPIRATORY FAILURE</b>					
<b>RENAL INSUFFICIENCY</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D 30263</b>		29d. Date signed (Month, Day, Year) <b>01-20-04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANCIS KHOO M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204</b>					
31. Date filed (Month, Day Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01779

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES

W

TYLER

2. Date of Death  
Month Day Year  
01-20-04

3. Time of Death  
1:30A

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

LORION @ Riverside

4b. City, Town, or Location of Death

BELCAMP

4c. County of Death

HARFORD

5. Social Security Number  
268-18-4359

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
81 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)  
4/7/1922

9. Birthplace (State or Foreign  
Country)  
OHIO

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

BELCAMP

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1208 MIST WOOD G

10f. Zip Code

21017

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MINISTRY

16b. Kind of Business/Industry

CHURCH

17. Father's Name (First, Middle, Last)

FRANK TYLER

18. Mother's Name (First, Middle, Maiden Surname)

MABEL MINNICH

19a. Informant's Name/Relationship (Type, Print)

FAYE TYLER - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1208 MIST WOOD G, BELCAMP, MD 21017

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

RIVERSIDE CEMETERY

Date

UNK

20c. Location - City or Town, State

TROY OHIO

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

#MO1148

22. Name and Address of Facility

FINK FUNERAL HOME, PA

426 CRAIN HIGHWAY, S., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final  
disease or condition  
resulting in death)

Arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Parkinson's disease

Due to (or as a consequence of):

d. Coronary disease

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J-L M.D.

29c. License number

P20661

29d. Date signed (Month, Day, Year)

1/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J-L Lee M.D.

669

Revolution St Havre de Grace

MD 21078

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State  
Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Funeral  
Director

State  
Registrar

44

JAMES W. TYLER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01780

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Patsy Torre, Jr.

2. Date of Death  
Month Day Year

Jan. 16 2004

3. Time of Death

1:05pm

4a. Facility Name (If not institution, give street and number)

311 Northlands Court

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

111-24-1379

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

03/25/1932

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

311 Northlands Court

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1954-56

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Research Analyst

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

James Patsy Torre, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Margaret A. D'Ambrosio

19a. Informant's Name/Relationship (Type, Print)

Patricia M. Torre- Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

311 Northlands Ct., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Angel Hill Cemetery

Date

1/19/04 Havre de Grace, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.

123 S. Washington, Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

11 MONTHS

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LIVER METASTASES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)29b. Signature and title of certifier  
  
MD

29c. License number

D29373

29d. Date signed (Month, Day, Year)

1/16/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC J. SEIFERT, MD 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01781

Certificate of Death

Reg. No.

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 4055.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CATHERINE A. TYLER		2. Date of Death Month Day Year January 21, 2004		3. Time of Death 5:00 a M
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare Long Green		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 216-40-1808	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 14, 1943	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 2928 East Fayette Street		10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker		16b. Kind of Business/Industry Perfect Parts Co.
	17. Father's Name (First, Middle, Last) James Brooks		18. Mother's Name (First, Middle, Maiden Surname) Catherine Johnson		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Teresa A. Pridgeon (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1637 Belt Street, Baltimore, Maryland 21230		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Location - City or Town, State Baltimore, Maryland
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21230 130 East Fort Avenue, Baltimore, Maryland		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 2/yr		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier		29c. License number D24276		29d. Date signed (Month, Day, Year) 1-22-04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Hudson St. Simon Scales MD					
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01782

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jacqueline A. Taylor

2. Date of Death

January 21, 2004

3. Time of Death

2:33 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-52-3079

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

5/2/50

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

602 S. BELNORD AVE.

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COMPUTER ANALYST

16b. Kind of Business/Industry

DANMAR  
MANUFACTURING

17. Father's Name (First, Middle, Last)

HENRY RUSSELL BROWN

18. Mother's Name (First, Middle, Maiden Surname)

DOLORES LOWE

19a. Informant's Name/Relationship (Type, Print)

JACQUELINE A. TAYLOR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

632 S. MONTFORD AVE. BALTIMORE, MD. 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BAYVIEW CREMATORY 1/25/04

Date

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

RACZOROWSKI FUNERAL HOME P.A.  
1201 DUNDALK AVE. BALTIMORE, MD. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 21, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Johnston, MD, Carnegie 568, Johns Hopkins Hospital, 600 N. Wolfe Street, Baltimore, MD 21207

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01783

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jeraldine

Thomas

2. Date of Death

Month

Day

Year

1

18

2004

3. Time of Death

2:p

M

4a. Facility Name (If not institution, give street and number)

Lorien Frankford N.H.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

231-56-6723

6. Sex

M

2

F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

10-27-45

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

2514 Harford Rd.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th gradeCollege (1-4 or 5+)  
4 yrs16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Dept. of Education

17. Father's Name (First, Middle, Last)

George

Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Edna

Thomas

19a. Informant's Name/Relationship (Type, Print)

Diane Jordan

Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5616 13th St. N.W. Apt. 206, Washington, D.C.

20011

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion Cem.

Date

1-24-04

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F.H. East

Baltimore, Md. 21202

1101 E. North Ave.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 hour

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 Yes 2 No  
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy  
4 Pregnant at time of death 5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an  
autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings available  
prior to completion of cause of  
death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation  
6 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

29b. Signature and title of certifier

29c. License number

D43386

29d. Date signed (Month, Day, Year)

1/23/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel R. Howard, MD 821 N. E. Ave 405 Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 26 per Dr., G827,01/23/04dhb

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01784

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

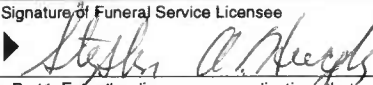
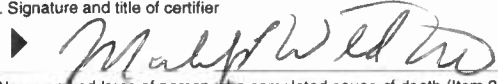

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Robert Louis Thompson, Sr.</b>		2. Date of Death Month <b>January</b> Day <b>19</b> Year <b>2004</b>		3. Time of Death <b>10:50 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Jacob's Well Assisted Living</b>			4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>
5. Social Security Number <b>160-24-3481</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 16, 1929</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Harford</b>	10c. City, Town or Location <b>Havre de Grace</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3912 Rock Run Road</b>		10f. Zip Code <b>21078</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operator</b>		16b. Kind of Business/Industry <b>Water Treatment Plant</b>			
17. Father's Name (First, Middle, Last) <b>Millard Hawkins Thompson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rosa Adelaide Bradford</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Loretta B. Thompson / Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3912 Rock Run Road, Havre de Grace, MD 21078</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rock Run U.M. Cemetery</b>		20c. Location - City or Town, State <b>1-22-04 Havre de Grace, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Malignant Melanoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of):  <b>c. _____</b> Due to (or as a consequence of):  <b>d. _____</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>d35522</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 20, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARK WILD 2 NORTH AVENUE BEL AIR MARYLAND 21014</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01785

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Wesley Tyson

2. Date of Death

January 18, 2004

3. Time of Death

12:00 PM

4a. Facility Name (If not institution, give street and number)

16 Huntington Place

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

219-16-4397

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 16, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16 Huntington Place

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Estimator

16b. Kind of Business/Industry

Fabrication

17. Father's Name (First, Middle, Last)

Alfred Stanley Tyson

18. Mother's Name (First, Middle, Maiden Surname)

Helen Elizabeth Walker

19a. Informant's Name/Relationship (Type, Print)

Carrie Lee Tyson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 Huntington Place, Bel Air, MD 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Christian Church Cem. 1-24-04 Joppa, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 d

b. West Nile Virus

Due to (or as a consequence of):

9 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43386

29d. Date signed (Month, Day, Year)

1/19/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dandel R. Howard, MD 821 N. Eukw #405 Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01786

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS

GAYLE

WHITE

2. Date of Death

January 17, 2004

3. Time of Death

7:45 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1080 CAYER DRIVE

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

219-26-6053

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

10/25/1940

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1080 CAYER DRIVE

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DD NDT use retired)

LABORER

16b. Kind of Business/Industry

GLOBE BLINDS

17. Father's Name (First, Middle, Last)

FRED E. WHITE

18. Mother's Name (First, Middle, Maiden Surname)

CHARLOTTE LATTAU

19a. Informant's Name/Relationship (Type, Print)

ADELAIDE HASLUP

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1080 CAYER DRIVE, GLEN BURNIE, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CEDAR HILL CEMETERY

Date

1/21/2004

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

#MO1148

22. Name and Address of Facility

FINK FUNERAL HOME, PA

426 CRAIN HIGHWAY, S, GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

23 yrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 23 2004

Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1. For State Registrar UNPEND ITEM 23a, 27&28a-1 PER M. 6827 1/23/04 JM  
State of Maryland Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2004 01787

3047

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>GLENN HAROLD WAGNER</b>		2. Date of Death Month <b>January</b> Day <b>13</b> Year <b>2004</b>		3. Time of Death <b>12:55 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Western Correctional Institution</b>		4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
5. Social Security Number	6. Sex <b>XXM</b> 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>35</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>11/5/1968</b>		9. Birthplace (State or Foreign Country) <b>IL</b>
Usual Residence of Decedent					
10a. State		10b. County		10c. City, Town or Location	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>AUTO MECHANIC</b>		16b. Kind of Business/Industry <b>AUTO REPAIR</b>	
17. Father's Name (First, Middle, Last) <b>KEITH WAGNER</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>NANCY DENNING</b>		
19a. Informant's Name/Relationship (Type, Print) <b>NANCY WAGNER - MOTHER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2615 McNEIL ROAD, ROCK FALLS, IL 61071</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BAYVIEW CREMATORY</b>		20c. Location - City or Town, State <b>1/17/2004 BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee <b>KELLY GRAGORY FINK #MO1148</b>		22. Name and Address of Facility <b>FINK FUNERAL HOME, PA 426 CRAIN HWY., S, GLEN BURNIE, MD 21061</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. NARCOTIC INTOXICATION</b> Due to (or as a consequence of): <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>1/13/04</b>		28b. Time of Injury <b>12:05 PM</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND IN CELL</b>		28f. Location (Street and Number or Rural Route Number, City, State, Zip Code) <b>WESTERN CORRECTIONAL INSTITUTE CUMBERLAND, MD</b>			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Patricia Aronica Blakemoore</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>January 14, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Patricia Aronica Blakemoore 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>Benjamin S. Sparks</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01788

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Evelyn Margaret Watts</b>				2. Date of Death Month <b>01</b> Day <b>17</b> Year <b>04</b>		3. Time of Death <b>2:00 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Maryland Masonic Home</b>				4b. City, Town, or Location of Death <b>Cockeysville</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>212 03 6433</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 22 1915</b>	9. Birthplace (State or Foreign Country) <b>Baltimore, Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore County</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>2002 Wintergreen Place</b>				10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Banking Industry</b>				
	17. Father's Name (First, Middle, Last) <b>Clarence E McJilton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosa Elizabeth Ruppert</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Karen A Watts (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2002 Wintergreen Place Baltimore, Maryland 21237</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cem. January 21 2004</b>		Date		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>Walter J. Sassin, Chiropractor</b>				22. Name and Address of Facility <b>Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. End Stage Dementia</b> Due to (or as a consequence of): <b>b. Atherosclerotic Vascular Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Arthritis, Depression, Osteoporosis</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>R. T. Liberto, MD.</b>		29c. License number <b>D2146X</b>		29d. Date signed (Month, Day, Year) <b>1/20/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT LIBERTO, MD. 3508 BANK ST. BALTO, MD 21224</b>									
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>				32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01789

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ADLENE WIMER

2. Date of Death

Jan. 15, 2004

3. Time of Death

2:25 p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

1022 Taylor Road

4b. City, Town, or Location of Death

Street

4c. County of Death

Harford

5. Social Security Number

219-22-4613

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

4/12/1925

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Street

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

728 Highland Road

10f. Zip Code

21154

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Postal Service

17. Father's Name (First, Middle, Last)

Gilbert L. Brock

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Cyle Wamsley

19a. Informant's Name/Relationship (Type, Print)

Shirley A. Johnson/Daugh.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1022 Taylor Road, Street, MD 21154

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Mem. Gdns

Date

1/19/04

20c. Location - City or Town, State

Bel Air, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Harkins Funeral Home, Inc., Delta, PA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSION

Due to (or as a consequence of):

b. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Daughter's home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier  
Bernard H. Ravitz M.D.

29c. License number

D36846

29d. Date signed (Month, Day, Year)

JANUARY 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernard H. Ravitz M.D. 5629 Lumberton Road White Hall MD 21161

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01790

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Elizabeth Waters

2. Date of Death

January 19, 2004 4:00A M

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

420 Morris Hill Avenue

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

217-28-4880

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 6, 1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

420 Morris Hill Avenue

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

NSA

17. Father's Name (First, Middle, Last)

Howard Truitt

18. Mother's Name (First, Middle, Maiden Surname)

Marguerite Purnell

19a. Informant's Name/Relationship (Type, Print)

Sharon Waters - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

404 Marley Station Rd. Glen Burnie, MD 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cem.

Date

1/24/04

20c. Location - City or Town, State

Balto. Co., MD

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.  
2501 Gwynns Falls Pkwy. Balto., MD 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Arrhythmia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
3 yearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Hypertensive Cardiovascular disease

Due to (or as a consequence of):

20 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. Seenivasan MD

29c. License number

D17743

29d. Date signed (Month, Day, Year)

01/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. SEENIVASAN, MD, 606 HAMMONDS LANE, SUITE 2-6, BALTO, MD, 21225

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **2004 01791**  
**Certificate of Death** Reg. No.

1- For State Registrar

Physician / Medical Examiner  
 Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Beth Warner</b>		2. Date of Death Month <b>January</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>2:40 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>219-96-2927</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>25</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Nov. 6, 1978</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>	
Usual Residence of Decedent					
10a. State <b>MD.</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>809 S. PONCA ST.</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (9-12) <b>11th</b> College (1-4 or 5+) <b>DISABLED</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DISABLED</b>		16b. Kind of Business/Industry <b>N/A</b>			
17. Father's Name (First, Middle, Last) <b>RICHARD ALLEN WARNER</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>CAROLYN J. GRAY</b>		
19a. Informant's Name/Relationship (Type, Print) <b>CALA WILD</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>810 S. PONCA ST. BALTO., MD. 21224</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BAYVIEW CREM.</b>		20c. Location - City or Town, State <b>BALTO. MD</b>	
21. Signature of Funeral Service Licensee <b>Thomas J. Skarda Jr.</b>		22. Name and Address of Facility <b>SKARDA FH. 2829 HUDSON ST. BALTO., MD. 21224</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory Failure</b> Due to (or as a consequence of): b. <b>Necrotizing Pneumonia</b> Due to (or as a consequence of): c. <b>Tricuspid Valve Endocarditis</b> Due to (or as a consequence of): d.					
23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Human Immunodeficiency Virus</b>					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>January 20, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. John Eckman 4940 Eastern Avenue Baltimore, Md 21224</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01792

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ELEANORA M. WILLINGER</b>		2. Date of Death Month <b>JAN</b> Day <b>17</b> Year <b>2004</b>		3. Time of Death <b>3:00</b> <b>P.</b> <b>M</b>	
4a. Facility Name (If not institution, give street and number) <b>9 MANIFOLD CT.</b>		4b. City, Town, or Location of Death <b>MIDDLE RIVER</b>		4c. County of Death <b>BALTO. CO.</b>	
5. Social Security Number <b>213-20-4497</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>DEC. 10, 1926</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>	
Usual Residence of Decedent					
10a. State <b>MD.</b>	10b. County <b>BALTO.</b>	10c. City, Town or Location <b>MIDDLE RIVER</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>9 MANIFOLD CT.</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>MANUFACTURER</b>		16. Kind of Business/Industry <b>WESTERN ELEC.</b>	
17. Father's Name (First, Middle, Last) <b>GEORGE BOWERS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>NETTIE DOUGLAS</b>			
19a. Informant's Name/Relationship (Type, Print) <b>LINDA WILLINGER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 MANIFOLD CT. BALTO., MD. 21220</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SACRAMENT OF JESUS</b>		20c. Location - City or Town, State <b>BALTO. MD.</b>	
21. Signature of Funeral Service Licensee <b>Thomas J. Skarda J.</b>		22. Name and Address of Facility <b>SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD. 21224</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Brain Cancer</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>					
Approximate Interval Between Onset and Death <b>3 months</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>[Signature] MD</b>		29c. License number <b>D0033847</b>		29d. Date signed (Month, Day, Year) <b>1/20/2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Vissing 3509 Eastern Ave Baltimore, MD. 21224</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01793

1- For State Register AMEND ITEM #10e PER FH G827 1/23/04 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MYRA WAGONHEIM</b>		2. Date of Death Month <b>Jan.</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>1:15 P M</b>
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Healthcare</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>217-58-6473</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>SEP. 25, 1928</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>8203 CRANWOOD COURT</b> <del>8203 CRANSWOOD COURT</del>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PROPERTY OWNER</b>
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry <b>REAL ESTATE</b>		17. Father's Name (First, Middle, Last) <b>MILTON SCHWABER</b>		
	18. Mother's Name (First, Middle, Maiden Surname) <b>CECELIA SAKOLSKY</b>		19a. Informant's Name/Relationship (Type, Print) <b>MARK WAGONHEIM / SON</b>		
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>38 RAISIN TREE CIRCLE - BALTIMORE, MD 21208</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON CHIZUK AMUNO</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Director <i>[Signature]</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. non-small cell lung cancer</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)				
	28b. Time of Injury <b>M</b>				
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	28d. Describe how injury occurred				
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <i>[Signature]</i>				
To Be Completed by Physician/Medical Examiner	29c. License number <b>D35254</b>				
	29d. Date signed (Month, Day, Year) <b>January 20, 2004</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Carole Miller MD 900 Patoma Ave Balt MD 21229</b>				
	31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>				
State Registrar	32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01794

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Weaver

2. Date of Death

January 16, 2004

3. Time of Death

8:00 AM

4a. Facility Name (If not institution, give street and number)

Heartland Health Care Center-Adelphi

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

577-42-6021

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 1, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1801 Metzert Road

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

maid

16b. Kind of Business/Industry

private residences

17. Father's Name (First, Middle, Last)

Carroll Young

18. Mother's Name (First, Middle, Maiden Surname)

Mary Briscoe

19a. Informant's Name/Relationship (Type, Print)

Frances L. Young/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1447 South Carolina SE Washington, DC 20003

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

00054566

29d. Date signed (Month, Day, Year)

1/16/04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sumitha Bhogevia, 120A East Toppra Road, Suite 230, Tocosen, MN 21286

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01795

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Curtis Williams</b>		2. Date of Death Month: <b>January</b> Day: <b>21</b> Year: <b>2004</b>		3. Time of Death <b>6:49 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>249-46-5475</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 2, 1931</b>	
	9. Birthplace (State or Foreign Country) <b>South Carolina</b>		10a. State <b>Maryland</b>		
To Be Completed by Funeral Director	10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>2563 Robb St.</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>10</b> College (1-4 or 5+): <b>0</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Utility Worker</b>		16b. Kind of Business/Industry <b>General Motors</b>		
	17. Father's Name (First, Middle, Last) <b>Clem Davis</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sally Williams</b>		
	19a. Informant's Name/Relationship (Type, Print) (Wife) <b>Mrs. Catherine Williams</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2563 Robb St. Balto. Md. 21218</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		20c. Location - City or Town, State <b>1/28/2004 Owings Mills, Md.</b>
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>anoxic brain injury</b> Due to (or as a consequence of): b. <b>acute myocardial infarction</b> Due to (or as a consequence of): c. <b>atherosclerotic coronary artery disease</b> Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death <b>6 days</b> <b>6 days</b> <b>10 years</b>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month: Day: Year:	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <b>[Signature] M.D.</b>		29c. License number <b>res-000</b>		29d. Date signed (Month, Day, Year) <b>January 21, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joshua Bernstein, M.D. Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, Maryland 21224</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Florence Watson</b>		2. Date of Death Month <b>January</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>01:45AM</b>	
4a. Facility Name (If not institution, give street and number) <b>The John Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>242-80-3046</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>55</b> Yrs.	If Under 1 Year Months Days	# Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 26, 1948</b>
9. Birthplace (State or Foreign Country) <b>South Carolina</b>					
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2808 Kennedy Ave.</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Private</b>			
17. Father's Name (First, Middle, Last) <b>Moses Watson Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Hartwell</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Ms. Bernice Watson (Daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2808 Kennedy Ave. Balto. Md. 21218</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		20c. Location - City or Town, State <b>1/26/2004 Dundalk, Md.</b>	
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Breast Carcinoma</b>					Approximate Interval Between Onset and Death <b>5 years</b>
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Dr. Nadeem Ahmed, Medical Doctor</b>		29c. License number <b>P16698</b>		29d. Date signed (Month, Day, Year) <b>January 20, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Nadeem Ahmed, The John Hopkins Hospital, 600 North Wolfe Street Baltimore, Maryland 21287</b>					
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01797

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Wooden

2. Date of Death

01

Day

19

Year

0934 AM

Time of Death

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-38-2143

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

11-21-1927

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1818 HARFORD AVE.

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

-12-

College (1-4or 5+)

-0-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEKEEPING

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

ROBERT CLARK SR.

18. Mother's Name (First, Middle, Maiden Surname)

DORA CLARK

19a. Informant's Name/Relationship (Type, Print)

LINDA E. CLARK (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1504 KIA CT. APT 3A BALTIMORE, MARYLAND 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MT. ZION CEMETERY

Date

1-24-2004

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

JONATHAN D. HIBNER

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.  
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Hypertension

Degenerative joint disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Elizabeth Turner

29c. License number

D0059300

29d. Date signed (Month, Day, Year)

1/21/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELIZABETH TURNER 1000 E. Eager St. Baltimore, MD 21202

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23e or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01798

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Du Ri Yi

2. Date of Death  
Month Day Year

January 21, 2004 8:15 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

213-08-3304

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 4, 1928

9. Birthplace (State or Foreign Country)

Korea

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Jessup

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7405 Beclare Court

10f. Zip Code

20794

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jong Man Yi

18. Mother's Name (First, Middle, Maiden Surname)

Kim

19a. Informant's Name/Relationship (Type, Print)

Sun Cha Walker - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7405 Beclare Court Jessup, Maryland 20794

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Pk.

Date

1/23/04

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

YMK. Hackman

22. Name and Address of Facility

Gary L. Kaufman Funeral Home At MMP., Inc.  
7250 Washington Blvd. Elkridge, Maryland 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Ischemic Colitis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature] MD

29c. License number

P48006

29d. Date signed (Month, Day, Year)

January 21, 2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KORI BORTLEY, 301 Hospital Dr, Glen Burnie, MD

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 23 2004

32. Registrar's Signature

[Signature]

ORIGINAL

VI, DU RI  
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#4a-c State of Maryland / Department of Health and Mental Hygiene

1- Amend Item#21 per MC827 1/23/04 EW  
Unopened Item#23a, Part II, 27, Per MC828, 2/19/04

Reg. No.

2004 01799

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard Raymond Brown</b>			2. Date of Death Month <b>January</b> Day <b>9</b> Year <b>2004</b>		3. Time of Death <b>5:25 A</b> M	
	4a. Facility Name (If not institution, give street and number) <b>Peninsula Regional Medical Center 5539 Whitesburg Road</b>			4b. City, Town, or Location of Death <b>Pocomoke Salisbury</b>		4c. County of Death <b>Worcester Wicomico</b>	
Funeral Director	5. Social Security Number <b>218-48-8748</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>55</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>August 6, 1948</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	10a. State <b>Maryland</b>			10b. County <b>Worcester</b>	10c. City, Town or Location <b>Pocomoke City</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No
10e. Street and Number <b>5539 Whitesburg Road</b>		10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Forestry</b>		16b. Kind of Business/Industry <b>Self Employed</b>			
17. Father's Name (First, Middle, Last) <b>Raymond Lloyd Brown</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Edna ----- Long</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara E. Brown - Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3200 Phillips Road, Salisbury, Maryland 21804</b>				
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wicomico Memorial Park</b>		20c. Location - City or Town, State <b>Salisbury, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Keith R Downey per DVR Mo1212</b>			22. Name and Address of Facility <b>Holloway Funeral Home, Professional Association 501 Snow Hill Road, Salisbury, Maryland 21804</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiomegaly with Myocardial Fibrosis</b> Due to (or as a consequence of): <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>							Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1</b> Yes <b>2</b> No <b>9</b> Unknown							23c. If yes, outcome of pregnancy <b>1</b> Live birth <b>2</b> Fetal death <b>4</b> Pregnant at time of death <b>5</b> Other (specify) <b>9</b> Unknown
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure Disorder</b>							
23e. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown							
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No							
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No							
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>Raymond McKeel MD</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>January 10, 2004</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYANN D KAREW 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>JAN 14 2004</b>		32. Registrar's Signature <b>Sparks</b>					

3049  
Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

W.C. J.  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01800

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARIE LILY LEWIS BOLDEN

2. Date of Death

JANUARY 11, 2004

3. Time of Death

5:45 AM

4a. Facility Name (If not institution, give street and number)

GLADYS SPELLMAN SPECIALTY HOSPITAL & NURSING FACILITY

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

244-76-5037

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOVEMBER 10, 1947

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

CHARLES

10c. City, Town or Location

LAPLATA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7745 HAWTHORNE ROAD

10f. Zip Code

20646

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

BENJAMIN JENKINS

18. Mother's Name (First, Middle, Maiden Surname)

MARY ELIZABETH JAMES EADDY

19a. Informant's Name/Relationship (Type, Print)

HARRY L. BOLDEN/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7745 HAWTHORNE ROAD, LAPLATA, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD VETERANS CEMETERY

Date

1/15/2004

20c. Location - City or Town, State

CHELTENHAM, MD

21. Signature of Funeral Service Licensee

LIDIA C. THORNTON JOHNSON

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.  
3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. STAPH SEPSIS

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d. HYPERTENSIVE CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D27577

29d. Date signed (Month, Day, Year)

01/11/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OPHNELL CUMBERBATCH, MD 8416 CENTRAL AVE. LANDOVER, MARYLAND 20785

31. Date filed (Month, Day, Year)

JAN 14 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01801

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>MARGARET E. BRANSON</u>				2. Date of Death Month <u>01</u> Day <u>09</u> Year <u>04</u>		3. Time of Death <u>1425 PM</u>		
	4a. Facility Name (If not institution, give street and number) <u>Chester River Hospital Center</u>				4b. City, Town, or Location of Death <u>Chester Town</u>		4c. County of Death <u>Kent</u>		
Funeral Director	5. Social Security Number <u>577 18 9741</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>84</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Oct 28, 1919</u>		
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>MD</u>		10b. County <u>Kent</u>		10c. City, Town or Location <u>Worton</u>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>13361 Fishing Valley Road</u>		10f. Zip Code <u>21678</u>		10g. Citizen of What Country? <u>United States</u>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>unknown</u> College (1-4or 5+) <u>unknown</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>		16b. Kind of Business/Industry <u>Own Home</u>		17. Father's Name (First, Middle, Last) <u>unknown Ellis</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>unknown Bryant</u>	
19a. Informant's Name/Relationship (Type, Print) <u>Clifford J. Gladu/Son</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>13361 Fishing Valley Road Worton, MD 21678</u>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Mt. Zion UM Cemetery</u>		20c. Location - City or Town, State <u>1-13-2004 Highland, MD</u>	
21. Signature of Funeral Service Licensee <u>Sharon Collins-Wright</u>		22. Name and Address of Facility <u>Harry H. Witzke's Family FH Inc.</u>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Respiratory failure</u>		23b. Immediate Cause (Final disease or condition resulting in death) <u>Chronic Obstructive Pulmonary Disease</u>		Approximate Interval Between Onset and Death <u>7 days</u>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Atrial fibrillation, DM type II; HTN; CHF;</u> <u>Osteoporosis; Alcohol; GERD</u>		23a. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>Neil Stoddard</u>		29c. License number <u>D50996</u>	
29d. Date signed (Month, Day, Year) <u>1/9/2004</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Neil Stoddard MD 100 Brown St. Chestertown MD 21620</u>		31. Date filed (Month, Day, Year) <u>JAN 12 2004</u>		32. Registrar's Signature <u>Sharon Collins-Wright</u>			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01802

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Rosaria H. Calabrese</b>		2. Date of Death Month <b>January</b> Day <b>10</b> Year <b>2004</b>		3. Time of Death <b>3:15 P M</b>	
4a. Facility Name (If not institution, give street and number) <b>3717 Dorsey Search Circle</b>		4b. City, Town, or Location of Death <b>Ellicott City</b>		4c. County of Death <b>Howard</b>	
5. Social Security Number <b>218 28 6037</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 10, 1929</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>		Usual Residence of Decedent			
10a. State <b>MD</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Ellicott City</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3717 Dorsey Search Circle</b>		10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookkeeper</b>		16b. Kind of Business/Industry <b>State of Maryland</b>			
17. Father's Name (First, Middle, Last) <b>Pietro Calabrese</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rosina Glorioso</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Anthony A. Calabrese/Brother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3717 Dorsey Search Circle Ellicott City, MD 21042</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. Location - City or Town, State <b>1-14-2004 Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <b>Shan Collins-Wilke</b>		22. Name and Address of Facility <b>Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Cordae arrest / Arrhythmia</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>00055171</b>		29d. Date signed (Month, Day, Year) <b>January 12, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SEBASTIAN JOHN 3023 EASTERN AVENUE BALTIMORE MD 21224</b>					
31. Date filed (Month, Day, Year) <b>JAN 12 2004</b>		32. Registrar's Signature <b>[Signature]</b>			



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01803

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kate Hackney Dixon

2. Date of Death

Month Day Year  
Jan 12, 2004

3. Time of Death

5:00 PM<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

7904 Surrattes Road

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

238 40 6158

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 12, 1931

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7904 Surratts Road

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Commerical

17. Father's Name (First, Middle, Last)

William Hackney

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Richardson

19a. Informant's Name/Relationship (Type, Print)

Bruce W. Cooke (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26867 North Sandgates Road, Mechanicsville, RD 20659

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lee Crematory Jan 14, 2004

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

S. S. Smith M00542

22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old

Alexandria Ferry Road, Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William T. Tanner

29c. License number

D35206

29d. Date signed (Month, Day, Year)

January 14, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William T. Tanner, M.D. 11701 Livingston Road, #101, Fort Washington, MD20744

31. Date filed (Month, Day, Year)

JAN 15 2004

32. Registrar's Signature

Kane H. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01804

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALBERT AUSTIN DODDS</b>				2. Date of Death Month <b>1</b> Day <b>7</b> Year <b>2004</b>		3. Time of Death <b>2003</b> M	
	4a. Facility Name (If not institution, give street and number) <b>Atlantic General Hospital</b>				4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>066-10-3236</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>7/10/1913</b>		9. Birthplace (State or Foreign Country) <b>NJ</b>		
	Usual Residence of Decedent				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Ocean Pines</b>			
	10e. Street and Number <b>26 Carriage Lane</b>				10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Vice President</b>		16b. Kind of Business/Industry <b>Shirt Co.</b>			
	17. Father's Name (First, Middle, Last) <b>Albert Avery Dodds</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie Christy</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Judith D. Ferdinand</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Windjammer RD Ocean Pines, MD 21811</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryrest Cemetery</b>		Date <b>1/12/04</b>		20c. Location - City or Town, State <b>Mahwah, NJ</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>The Burbage Funeral Home</b> <b>108 William st. Berlin, MD 21811</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Respiratory Failure</b> Due to (or as a consequence of): <b>Chronic Obstructive Pulmonary Disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Coronary Artery Disease</b>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D28769</b>		29d. Date signed (Month, Day, Year) <b>1/8/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nicholas N. Borodulia, MD</b> <b>1209 Coastal Highway</b> <b>Pawcatuck Island, RI 02864</b>								
31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>				32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item 26 per CS/DVRC827,01/23/04dlb State of Maryland / Department of Health and Mental Hygiene 2004 01885  
Certificate of Death

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Violet Blanche Louise Duvall				2. Date of Death Month Day Year January 14, 2004		3. Time of Death 11:50 P.M.	
	4a. Facility Name (If not institution, give street and number) 12635 Mummert Road				4b. City, Town, or Location of Death Clear Spring		4c. County of Death Washington	
Funeral Director	5. Social Security Number 220-28-2765		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth Month Day Year Feb. 22, 1922	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Clear Spring	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 12635 Mummert Road		10f. Zip Code 21722		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Claude Daniel Sier				18. Mother's Name (First, Middle, Maiden Surname) Nettie Blanche Perkins			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Pamela Sue Weddle/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12635 Mummert Road, Clear Spring, MD 21722			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) Mount Olivet Cemetery		20c. Location - City or Town, State Jan. 19, 2004 Frederick, MD 21701		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Richard C. C. Busford		22. Name and Address of Facility M00021 Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a. <u>END Stage Dementia</u> Due to (or as a consequence of): b. <u>Hypothyroid</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death YRS YE			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ANOREXIA</u> <u>INCONTINENCE</u>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. Allen Reilly MD		29c. License number D54749		29d. Date signed (Month, Day, Year) 01 16 2004	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Allen Reilly, M.D., 801 Toll House D-1, Frederick, Maryland 21701							
State Registrar	31. Date filed (Month, Day, Year) JAN 22 2004		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01806

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Conrado Embalsado Emperado			2. Date of Death Month Day Year January 11, 2004		3. Time of Death 1907 M	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital			4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 068-48-5701	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 4, 1931	9. Birthplace (State or Foreign Country) Philippine Is.
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Clinton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 6303 Elm Way			10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) BA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant		16b. Kind of Business/Industry U.S. Fish and Wildlife Service		
	17. Father's Name (First, Middle, Last) Martiniano Emperado			18. Mother's Name (First, Middle, Maiden Surname) Margerita Embalsado			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mercedes Emperado (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6303 Elm Way Clinton, Maryland 20735			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State * <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Maryland		20d. Date January 16, 2004
	21. Signature of Funeral Service Licensee [Signature] MO0542		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. cerebrovascular Accident Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cancer prostate						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier [Signature]		29c. License number D46478		29d. Date signed (Month, Day, Year) 1.12.04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Patel, MD 7501 Surratts Rd. Clinton MD 20735							
31. Date filed (Month, Day, Year) JAN 15 2004		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, a Medical Examiner must be notified at once.

Emperado, Conrado expired  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01807

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23b or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Mary Louise Emmert-Ruleman</b>		2. Date of Death Month Day Year <b>January 9, 2004</b>		3. Time of Death <b>1:10PM M</b>
4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>		4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>
5. Social Security Number <b>577-20-6442</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Oct. 11, 1922</b>	9. Birthplace (State or Foreign Country) <b>Washington DC</b>
Usual Residence of Decedent				
10a. State <b>Maryland</b>	10b. County <b>Prince George's</b>	10c. City, Town or Location <b>College Park</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number <b>5021 Niagra Road</b>		10f. Zip Code <b>20740</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse (Administrative)</b>		16b. Kind of Business/Industry <b>WSSC</b>		
17. Father's Name (First, Middle, Last) <b>Dennis James Murphy</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Gertrude Weeden</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Dennis Emmert (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5505 Flounder Ct. Waldorf, Maryland 20603</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>
21. Signature of Funeral Service Licensee <b>Shirley Smith</b> M00542		22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ACUTE MYOCARDIAL INFARCTION</b> a. Due to (or as a consequence of): <b>BRONCHOPNEUMONIA / C.O.R.D.</b> b. Due to (or as a consequence of): <b>CORONARY ARTERY DISEASE</b> c. Due to (or as a consequence of): <b>ATHEROSCLEROSIS</b> d. <b>ATHEROSCLEROSIS</b>				Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <b>Dr. Don M. Coleman</b>		29c. License number <b>MD-57614</b>		29d. Date signed (Month, Day, Year) <b>1/9/04</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. DON M. COLEMAN 7600 Carroll Avenue Takoma Park, Maryland</b>				
31. Date filed (Month, Day, Year) <b>JAN 15 2004</b>		32. Registrar's Signature <b>Shirley Smith</b>		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01808

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN LOUISE SPIDE EDLER

2. Date of Death

Jan. 8, 2004

3. Time of Death

5:30 PM

4a. Facility Name (If not institution, give street and number)

Salisbury Rehab and Nursing Center

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

5. Social Security Number

216-09-6124

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 12, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

200 Civic Ave

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Management

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Edward Coffin

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Twigg

19a. Informant's Name/Relationship (Type, Print)

Paul Spide/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

305 Warren Place, Washington, NC 27889

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

First Baptist Cemetery

Date

1/12/04

20c. Location - City or Town, State

Pocomoke City, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Melson Funeral Home  
103 Linden Ave., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. congestive cardiomyopathy  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30853

29d. Date signed (Month, Day, Year)

1/9/04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles D. Silva Jr

1346 S. Division St. Suite, Salisbury, Md. 21804

31. Date filed (Month, Day, Year)

JAN 12 2004

32. Registrar's Signature

State Registrar

HELEN L. EDLER  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item 24a per verb., 6827, 01/23/04  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death  
Reg. No. 2004 01809

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Beulah J. Friend</b>			2. Date of Death Month <b>01</b> Day <b>20</b> Year <b>04</b>		3. Time of Death <b>12:25 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>			4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>215-36-7686</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Jul 15, 1937</b>		9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent						
10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>526 Necessity Street</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>			16b. Kind of Business/Industry <b>own home</b>	
17. Father's Name (First, Middle, Last) <b>Jacob Mullenax</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lenora Evans Mullenax</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Clifford Friend son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>200 Braddock Heights Frostburg MD 21532</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glendale Cemetery</b>		Date <b>1/24/2004</b>		20c. Location - City or Town, State <b>Flintstone MD</b>
21. Signature of Funeral Service Licensee <b>James J. Sepler</b>			22. Name and Address of Funeral Home <b>Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Coronary Arteriosclerotic HEART DISEASE</b> Due to (or as a consequence of): a. <b>Coronary Arteriosclerotic HEART DISEASE</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>48 hours</b>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Arteriosclerotic HEART DISEASE</b> <b>Diabetes Mellitus</b> <b>Diabetic Renal Disease</b>							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>Robert Welik</b>			29c. License number <b>D31875</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 21 2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Robert F Welik 900 Seton Drive, Cumb. Md. 21502</b>							
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>			32. Registrar's Signature <b>[Signature]</b>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

James

2. Date of Death

January 12 2004

3. Time of Death

21:26 M

4a. Facility Name (If not institution, give street and number)

Sonoma Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

219 48 6650

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

8. Date of Birth

Oct 24, 1946

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

PA

10b. County

Cumberland

10c. City, Town or Location

Newburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23 Peebles Road

10f. Zip Code

17240

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Commerical

17. Father's Name (First, Middle, Last)

Ettore Guido

18. Mother's Name (First, Middle, Maiden Surname)

Erma Knight

19a. Informant's Name/Relationship (Type, Print)

Edna L. Gudio (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23 Peebles Road, Newburg, PA 17240

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Memorial Gardens

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

Lee Funeral Home, Inc

22. Name and Address of Facility

Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gram Negative Sepsis

Approximate Interval Between Onset and Death

24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christopher G. Williams

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 12 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher G. Williams, MD 600 North Wolfe Street, Baltimore, MD 21287-9106

31. Date filed (Month, Day, Year)

JAN 15 2004

32. Registrar's Signature

James H. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01811

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EMIL E. GUSTAFSON</b>			2. Date of Death Month <b>JANUARY</b> Day <b>6</b> Year <b>2004</b>		3. Time of Death <b>0645 M</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>470-22-0495</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>3-19-24</b>		9. Birthplace (State or Foreign Country) <b>MN</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>Worcester</b>	10c. City, Town or Location <b>Berlin</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>14 Fishermans Drive</b>			10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clergyman</b>		16b. Kind of Business/Industry <b>Religion</b>	
	17. Father's Name (First, Middle, Last) <b>Oscar Otto Gustafson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hildur Lindberg</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Charlotte W. Gustafson</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14 Fishermans Drive Berlin, Md. 21811</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crem.</b>		Date <b>1-7-04</b>		20c. Location - City or Town, State <b>Salisbury, MD.</b>
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Ulrich Funeral Home Berlin, Md. 21811</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DIABETIS MELLITUS</b> <b>PNEUMONIA</b>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier M.D.		29c. License number <b>D57952</b>		29d. Date signed (Month, Day, Year) <b>1/6/2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Babulal Das 106 Milford ST # 504B Salisbury MD 21804</b>							
31. Date filed (Month, Day, Year) <b>JAN 08 2004</b>		32. Registrar's Signature 					

Emil E. Gustafson 470-22-0495

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

O.H. 5+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Unpend Item #23a, 27, 28a-1 per MC 6828 2/27/04  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2004 01812

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Amy Elizabeth Gallion			2. Date of Death Month Day Year January 14, 2004		3. Time of Death 4:10 AM <sup>M</sup>	
	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center			4b. City, Town, or Location of Death Bel Air		4c. County of Death Harford	
Funeral Director	5. Social Security Number 217-02-1627	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 21 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 27, 1982	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Harford	10c. City, Town or Location Bel Air		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1405 Landis Circle		10f. Zip Code 21015		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Child Care		16b. Kind of Business/Industry Athletic Club		
	17. Father's Name (First, Middle, Last) Thomas Dale Gallion			18. Mother's Name (First, Middle, Maiden Surname) Kimberly Anne Kries			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kimberly A. Gallion / Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 Landis Circle, Bel Air, MD 21015			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Grdns 1-20-04		20c. Location - City or Town, State Bel Air, Maryland		
	21. Signature of Funeral Service Licensee Charles A. Emery, Jr.		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Acute alcohol intoxication</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found 1/14/04		28b. Time of Injury Unknown <sup>M</sup>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Unknown		28d. Describe how injury occurred Unknown					
28f. Location (Street and Number or Rural Route Number, City or Town, State) Unknown		28g. Location (Street and Number or Rural Route Number, City or Town, State) Unknown					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier Dr. [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 15, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. [Signature] 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) JAN 23 2004		32. Registrar's Signature [Signature]					



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01813

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Helen Marguerite Baker Williams Sober</i>				2. Date of Death Month <i>1</i> Day <i>10</i> Year <i>2004</i>		3. Time of Death <i>5:00A M</i>	
	4a. Facility Name (If not institution, give street and number) <i>Upper Chesapeake Medical Center</i>				4b. City, Town, or Location of Death <i>Bel Air</i>		4c. County of Death <i>Harford</i>	
Funeral Director	5. Social Security Number <i>492-50-9190</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>75</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>1-7-1929</i>	
	9. Birthplace (State or Foreign Country) <i>Arkansas</i>		10a. State <i>Maryland</i>		10b. County <i>Harford</i>		10c. City, Town or Location <i>Aberdeen</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <i>77 Baker Street</i>		10f. Zip Code <i>21001</i>	
	10g. Citizen of What Country? <i>USA</i>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>2</i>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Secretary</i>				16b. Kind of Business/Industry <i>Moving Company</i>		17. Father's Name (First, Middle, Last) <i>Clarence Elmer Baker</i>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <i>Lillie Hagood</i>				19a. Informant's Name/Relationship (Type, Print) <i>Capt. Harry Sober - Husband</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>77 Baker Street Aberdeen, Md 21001</i>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Angel Hill Cemetery</i>		20c. Location - City or Town, State <i>1-13-2004 Harford County, Md</i>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Kerstin Amy Unglesbee</i>				22. Name and Address of Facility <i>Tarring-Cargo Funeral Home, P.A. 3335 Parke Street Aberdeen, Md 21001</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Metastatic Breast Cancer</i>	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Left Lower Lobe Pneumonia</i> <i>Left Upper Extremity Thrombosis</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>	
	29c. License number <i>MD H0054439</i>				29d. Date signed (Month, Day, Year) <i>January 10, 2004</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Vincent A Giminard DO, 602 S. Atwood Rd, *208 Bel Air, MD 21014</i>	
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <i>JAN 12 2004</i>				32. Registrar's Signature <i>[Signature]</i>		33. State Registrar	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01814

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Stanley Noel Kolpack</b>		2. Date of Death Month <b>January</b> Day <b>11</b> Year <b>2004</b>		3. Time of Death <b>2:58 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>		4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince George's</b>
Funeral Director	5. Social Security Number <b>579-58-7995</b>	6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>55</b> Yrs.	8. Date of Birth Month <b>Jan.</b> Day <b>11</b> Year <b>1949</b>	9. Birthplace (State or Foreign Country) <b>Washington DC</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Clinton</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No
	10e. Street and Number <b>6206 Buckler Road</b>		10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>8th</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A Disabled</b>		16b. Kind of Business/Industry <b>N/A Disabled</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Stanley Kolpack Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Thelma Lucas</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Kolpack (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6206 Buckler Road Clinton, Maryland 20735</b>		
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>		20c. Location - City or Town, State <b>2004 Clinton, Maryland</b>
	21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Stroke</b>				
23b. Immediate Cause (Final disease or condition resulting in death) <b>Stroke</b>					
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Stroke</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1</b> Yes <b>2</b> No <b>9</b> Unknown					
23c. If yes, outcome of pregnancy <b>1</b> Live birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy <b>4</b> Pregnant at time of death <b>5</b> Other (specify)					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b>					
23e. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown					
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No					
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No					
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No					
26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <b>1</b> Yes <b>2</b> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>[Signature]</b>					
29c. License number <b>50454</b>					
29d. Date signed (Month, Day, Year) <b>January 12, 04</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>9801 Georgia Ave Suite 3-41 Silver Spring MD 20902</b>					
31. Date filed (Month, Day, Year) <b>JAN 15 2004</b>					
32. Registrar's Signature <b>[Signature]</b>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01815

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Franklin Kenney, Sr.</b>			2. Date of Death Month <b>January</b> Day <b>10</b> Year <b>2004</b>		3. Time of Death <b>12:15<sup>M</sup></b>		
	4a. Facility Name (If not institution, give street and number) <b>Charlotte Hall Veterans Home</b>			4b. City, Town, or Location of Death <b>Charlotte Hall</b>		4c. County of Death <b>St. Mary's</b>		
Funeral Director	5. Social Security Number <b>233-26-9535</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 29, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Lothian</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4608 Hinchingham Lane</b>		10f. Zip Code <b>20711</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Hospitality</b>		16b. Kind of Business/Industry <b>Food Service</b>			
	17. Father's Name (First, Middle, Last) <b>William Kenney</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel Kissner</b>		19a. Informant's Name/Relationship (Type, Print) <b>Charles F. Kenney, Jr. (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4608 Hinchingham Lane Lothian, Maryland 20711</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Memorial Gardens 2004</b>		20c. Location - City or Town, State <b>Waldorf, Maryland</b>		20d. Date of Disposition <b>Jan. 15, 2004</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Lee Funeral Home, Inc.</b>		22b. Address <b>6633 Old Alexandria Ferry Road Clinton, MD 20735</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. congestive heart failure</b> <b>b. Hypertension</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> <b>d.</b>		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month _____ Day _____ Year _____	
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) _____ 28b. Time of Injury _____ M _____ 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred _____		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) _____		28f. Location (Street and Number or Rural Route Number, City or Town, State) _____			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D0056949</b>		29d. Date signed (Month, Day, Year) <b>1/13/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>16620 CRAIN HWY, STG-102</b>		30b. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>B. Karnakshi, MD</b>		30c. Address <b>LA PLATA, MD - 20646</b>				
31. Date filed (Month, Day, Year) <b>JAN 15 2004</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01816

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Louise Kilby</b>				2. Date of Death Month Day Year <b>January 7, 2004</b>		3. Time of Death <b>6:06A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Civista Medical Center</b>				4b. City, Town, or Location of Death <b>LaPlata</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>579-38-0132</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Aug. 10, 1930</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>		
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Charles</b>	
10c. City, Town or Location <b>Pomfret</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>9415 Marshall Corner Road</b>		
10f. Zip Code <b>20675</b>				10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>		
17. Father's Name (First, Middle, Last) <b>Charles Gaertner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lorraine Hawkins</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Henry Kilby (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 187 Pomfret, Maryland 20675</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		20c. Location - City or Town, State <b>2004 Brentwood, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Kelli R. Patten MD1190</b>				22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Respiratory failure</b> Due to (or as a consequence of): <b>Chronic Obstructive Pulmonary Disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Metastatic breast cancer</b>								Approximate Interval Between Onset and Death <b>days</b> <b>years</b>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Metastatic breast cancer</b>								23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <b>B. Larry Jenkins, MD</b>				29c. License number <b>D33426</b>		29d. Date signed (Month, Day, Year) <b>1/8/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>B. Larry Jenkins, MD 111 LaGrange Ave. PO Box 2665 LaPlata, MD 20646-1724</b>								
31. Date filed (Month, Day, Year) <b>JAN 15 2004</b>				32. Registrar's Signature <b>Steve B. Spivey</b>				

Reg. No.

**1- For State Registrar**

e2004 018 7

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Betty May Lomax

2. Date of Death Month January Day 11, Year 2004

3. Time of Death 3:30PM

4a. Facility Name (If not institution, give street and number) 7805 Mike Shapiro Drive

4b. City, Town, or Location of Death Clinton

4c. County of Death Prince George's

5. Social Security Number 075-22-5676

6. Sex 1 Male 2 Female 3 X

7. Age (In yrs. last birthday) 74 Yrs.

8. Date of Birth (Month, Day, Year) Aug. 23, 1929

9. Birthplace (State or Foreign Country) New York

10a. State Maryland

10b. County Prince George's

10c. City, Town or Location Clinton

10d. Inside City Limits 1 Yes 2 No 3 X

10e. Street and Number 7805 Mike Shapiro Drive

10f. Zip Code 20735

10g. Citizen of What Country? U.S.A.

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 5 X

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 X

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 3 X

14. Race - American Indian, Black, White, etc. Specify: African-American

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Administrator Assistant

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last) Arthur George Leighano

18. Mother's Name (First, Middle, Maiden Surname) Elsie Lee

19a. Informant's Name/Relationship (Type, Print) Michael Lomax (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17100 Usher Place Upper Marlboro, Maryland 20772

20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory

20c. Location - City or Town, State Jan. 12, 2004 Clinton, Maryland

21. Signature of Funeral Service Licensee S. S. Smith

22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of Pancreas Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):

23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

24a. Was an autopsy performed? 1 Yes 2 No 3 X

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 X

25. Was case referred to medical examiner? 1 Yes 2 No 3 X

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No 3 X

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Sam Tellawi

29c. License number D34274

29d. Date signed (Month, Day, Year) 1-12-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sam Tellawi, M.D. 7700 Old Branch Avenue #B-102 Clinton, Maryland 20735

31. Date filed (Month, Day, Year) JAN 15 2004

32. Registrar's Signature

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01818

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jennie Bloniarz Laiko</b>			2. Date of Death Month Day Year <b>January 12, 2004</b>		3. Time of Death <b>10:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Millennium Health and Rehab. Center</b>			4b. City, Town, or Location of Death <b>Fort Washington</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>014-07-3440</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 31, 1913</b>	9. Birthplace (State or Foreign Country) <b>Mass.</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Fort Washington</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>9611 Caltor Lane</b>		10f. Zip Code <b>20744</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Management</b>		16b. Kind of Business/Industry <b>Retail</b>		
	17. Father's Name (First, Middle, Last) <b>Sylvester Bloniarz</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Kurnik</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>John Ferus (Son)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Watuppa Road Westport, MA 02790</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		Date <b>Jan 14, 2004</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>end stage Alzheimer's dementia</b> <b>Failure to thrive</b>						
	23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Failure to thrive</b>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D-24535</b>		29d. Date signed (Month, Day, Year) <b>01.13.04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Laxmi N. Berwa, M.D. 7700 Old Branch Avenue #C101 Clinton, Maryland 20735</b>							
31. Date filed (Month, Day, Year) <b>JAN 15 2004</b>				32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1B3

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01819

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM ROLAND LANCASTER, JR</b>				2. Date of Death Month <b>1</b> Day <b>5</b> Year <b>2004</b>		3. Time of Death <b>7:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>504 S. Baltimore Ave.</b>				4b. City, Town, or Location of Death <b>Ocean City</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>212-48-7502</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6/28/1946</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Ocean City</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>504 S. Baltimore Ave.</b>			
	10f. Zip Code <b>21842</b>				10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Detailer</b>		16b. Kind of Business/Industry <b>Auto Repair</b>			
	17. Father's Name (First, Middle, Last) <b>William Roland Lancaster, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gloria Dawson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Kathleen Lancaster</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4921 Herring Run Dr. Baltimore, MD 21214</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cape Henlopen Crematory</b>		20c. Location - City or Town, State <b>Frankford, DE</b>		20d. Date <b>1/7/04</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>The Burbage Funeral Home 108 William St. Berlin, MD 21811</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>CARD</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>SEVERAL YRS</b>							
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES, HEAVY SMOKER</b>								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
26. Place of Death (Check only one)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i> 29c. License number <b>D 06241</b> 29d. Date signed (Month, Day, Year) <b>1-6-04</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DOROTHY C. HOLZWORTH M.D. 203 SNOW ST. SNOW HILL, MD. 21863</b>								
31. Date filed (Month, Day, Year) <b>JAN 08 2004</b> 32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

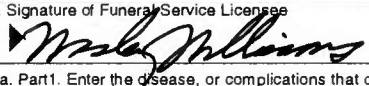


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01820

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Wanda Faye Lucas</b>				2. Date of Death Month Day Year <b>January 10, 2004</b>		3. Time of Death <b>11:20p<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>5 Beth Court</b>				4b. City, Town, or Location of Death <b>Indian Head</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>212-72-2817</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>45</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 18, 1958</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Indian Head</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>5 Beth Court</b>				10f. Zip Code <b>20640</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Program Analyst</b>		16b. Kind of Business/Industry <b>U.S. Government</b>		
17. Father's Name (First, Middle, Last) <b>Ronald B. Latham</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Patricia Q. Twiford</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ronald L. Lucas Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Beth Court, Indian Head, Md. 20640</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Funeral Service Alexandria, Virginia</b>		Date <b>Jan. 13, 2004</b>		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee  <b>M00668</b>				22. Name and Address of Facility <b>Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>BREASTCANCER</b>								
23b. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
23c. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D2F352</b>		29d. Date signed (Month, Day, Year) <b>1/13/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P.O. Box 1703 La Plata Md 20646</b>								
31. Date filed (Month, Day, Year) <b>JAN 13 2004</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01821

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM W. LOGAN</b>				2. Date of Death Month <u>January</u> Day <u>2</u> Year <u>2004</u>				3. Time of Death <u>1855</u> M	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>				4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>180-16-8497</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8-15-1922</b>		9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>	
	Usual Residence of Decedent				10a. State <b>DELAWARE</b>		10b. County <b>SUSSEX</b>		10c. City, Town or Location <b>LEWES</b>	
To Be Completed by Funeral Director	10a. State <b>DELAWARE</b>				10b. County <b>SUSSEX</b>				10c. City, Town or Location <b>LEWES</b>	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>77 PRINCE GEORGE DRIVE</b>				10f. Zip Code <b>19958</b>	
	10g. Citizen of What Country? <b>US</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>42-45</b> If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESMAN</b>				16b. Kind of Business/Industry <b>SEWING MACHINES</b>				17. Father's Name (First, Middle, Last) <b>WILLIAM W. LOGAN</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>LAURA BLACK</b>				19a. Informant's Name/Relationship (Type, Print) <b>MARGARET LOGAN/ WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>77 PRINCE GEORGE DR., LEWES, DE. 19958</b>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>MELSON'S CAFE</b>				20c. Location - City or Town, State <b>1-4-04 FRANKFORD, DELAWARE</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				21. Signature of Funeral Service Licensee <b>MELSON FUNERAL SERVICES, LTD.</b>				21. Signature of Funeral Service Licensee <b>LONG NECK ROAD, MILLSBORO, DE. 19966</b>	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Shock + Collapse, presumed septic</b> Due to (or as a consequence of): b. <b>Mycosis Fungoides with ascites, pleural effusions</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>2 weeks</b> <b>2 + years</b>				23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				23d. Date of delivery Month <u>  </u> Day <u>  </u> Year <u>  </u>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		
28b. Time of Injury M <u>  </u>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D-59475</b>				29d. Date signed (Month, Day, Year) <b>1-2-04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Yvonne Lyles 100 E. Carroll St. Salisbury MD 21801</b>				31. Date filed (Month, Day, Year) <b>JAN 06 2004</b>				32. Registrar's Signature <i>[Signature]</i>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01822

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Josephine Wilberger Miller</b>		2. Date of Death Month <b>January</b> Day <b>13</b> Year <b>2004</b>		3. Time of Death <b>6:30A M</b>
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>
Funeral Director	5. Social Security Number <b>578-58-0939</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Sept. 19, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		
To Be Completed by Funeral Director	10b. County <b>Calvert</b>		10c. City, Town or Location <b>Solomons</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>11450 Ashbury Circle #206</b>		10f. Zip Code <b>20688</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>		16b. Kind of Business/Industry <b>Health Care</b>		
	17. Father's Name (First, Middle, Last) <b>William Granvale Wilberger</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie Lind Soupley</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Linda Salisbury (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5225 Chippewa Place Alexandria Virginia 22312</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Location - City or Town, State <b>Suitland, Maryland</b>
	21. Signature of Funeral Service Licensee <b>John D. Tapp</b>		22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Ischemic colitis</b>		Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>David J. Tardio MD</b>		29c. License number <b>047610</b>	
29d. Date signed (Month, Day, Year) <b>January 14, 2004</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David J. Tardio, M.D. 110 Hospital Road Suite 310, Prince Frederick, MD 20678</b>			
31. Date filed (Month, Day, Year) <b>JAN 15 2004</b>		32. Registrar's Signature <b>Steven H. Sparks</b>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perennial. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01023

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EUNICE MAE MARSHALL

2. Date of Death

January 7 2004

3. Time of Death

0959 M

4a. Facility Name (If not institution, give street and number)

Annisola Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

214-30-7929

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

12/11/1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

508 Walnut Street

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Raymond Marshall

18. Mother's Name (First, Middle, Maiden Surname)

Delcie Aydelotte

19a. Informant's Name/Relationship (Type, Print)

William Hudson, Esq. (Personal Rep)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 Market St., Pocomoke City, MD 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Remson Cemetery

Date

1/10/2004

20c. Location - City or Town, State

Stockton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Nelson Funeral Home, P.A.  
103 Linden Ave., Pocomoke City, MD 2185123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *Multorgan Failure*

Due to (or as a consequence of)

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *Pneumonia*

Due to (or as a consequence of):

c. *CHF*

Due to (or as a consequence of):

d. *Acute fib. Atherosclerosis*

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D17181

29d. Date signed (Month, Day, Year)

1/7/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bal Agarwal 100 E. Carroll St. Salisbury MD 21804

31. Date filed (Month, Day, Year)

JAN 08 2004

32. Registrar's Signature

State

Registrar

Baltimore, Maryland 21215-0036

Eunice Marshall 214-30-7929  
Division of Vital Records, P.O. Box 68760,permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
important: if item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Unpend Items 23a, 27, 28a-f per ME, G828, 0213/04dbb  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)  
**John Thomas Manning, Jr.**

2. Date of Death  
Month Day Year  
**JANUARY 18, 2004**

3. Time of Death  
**1:57 P M**

Funeral  
Director

4a. Facility Name (If not institution, give street and number)  
**108 E. MAIN STREET**

4b. City, Town, or Location of Death  
**SUDLERSVILLE**

4c. County of Death  
**QUEEN ANNES CO**

5. Social Security Number  
**219-86-7662**

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)  
**41** Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth (Month, Day, Year)  
**09/10/1962**

9. Birthplace (State or Foreign Country)  
**Maryland**

Usual Residence of Decedent

10a. State  
**Maryland**

10b. County  
**Queen Anne's**

10c. City, Town or Location  
**Sudlersville**

10d. Inside City Limits  
☒ Yes ☐ No

10e. Street and Number  
**108 E. Main Street**

10f. Zip Code  
**21668**

10g. Citizen of What Country?  
**USA**

11. Marital Status  
☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.  
Specify: **White**

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) **10** College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
**Maintenance Manager**

16b. Kind of Business/Industry  
**Maintenance**

17. Father's Name (First, Middle, Last)  
**John Thomas Manning, Sr.**

18. Mother's Name (First, Middle, Maiden Surname)  
**Dorothy Townsend**

19a. Informant's Name/Relationship (Type, Print)  
**Ella Baker/Sister**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
**345 Kesselring Ave., Dover, DE 19904**

20a. Method of Disposition  
☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
**Asbury Cemetery**

Date  
**01/22/2004**

20c. Location - City or Town, State  
**Millington, Maryland**

21. Signature of Funeral Service Licensee  
**Ray B. Fellows**

22. Name and Address of Facility  
**Fellows, Helfenbein & Newnam Funeral Home, P.A  
370 W. Cypress Street, Millington, MD 21651**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
**Acute Alcohol Intoxication and Atherosclerotic Cardiovascular Disease complicated by Hypothermia**

Approximate Interval Between Onset and Death

Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy  
☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?  
☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
☒ Yes ☐ No

25. Was case referred to medical examiner?  
☒ Yes ☐ No

26. Place of Death (Check only one)  
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) **SCENE**

27. Manner of Death  
☐ Natural ☐ Pending investigation ☐ Suicide ☐ Homicide ☒ Accident ☐ Could not be determined

28a. Date of Injury (Month, Day Year)  
**01/18/04**

28b. Time of Injury  
**UNKNOWN** M

28c. Injury at Work?  
☐ Yes ☒ No

28d. Describe how injury occurred  
**Subject exposed to cold**

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
**Home**

28f. Location (Street and Number or Rural Route Number, City or Town, State)  
**108 E. Main St., Sudlersville, MD**

29a. Certifier  
(Check only one)  
☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
**Monte M. Yule MD**

29c. License number  
**O C M E**

29d. Date signed (Month, Day, Year)  
**JANUARY 19, 2004**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
**Mary Ann A. Koron**

**111 Penn Street, Baltimore, Maryland 21201**

31. Date filed (Month, Day, Year)  
**JAN 23 2004**

32. Registrar's Signature

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01825

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGOT EASTON RYAN</b>		2. Date of Death Month <b>1</b> Day <b>10</b> Year <b>2004</b>		3. Time of Death <b>0620 M</b>
	4a. Facility Name (If not institution, give street and number) <b>Atlantic General Hospital</b>		4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>
Funeral Director	5. Social Security Number <b>128-38-3632</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>5/22/1909</b>	9. Birthplace (State or Foreign Country) <b>NY</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Worcester</b>	10c. City, Town or Location <b>Berlin</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1 Meadow St.</b>		10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>USA</b>
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>William J. Ryan</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Louise Granger</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Margot Woods</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25 Clubhouse Dr. Ocean Pines, MD 21811</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery</b>		20c. Location - City or Town, State <b>Brooklyn, NY</b>
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>The Burbage Funeral Home 108 William St. Berlin, MD 21811</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>pneumonia</b> Due to (or as a consequence of): b. <b>Congestive Heart Failure</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and Title of certifier <i>[Signature]</i>		29c. License number <b>H 00585132</b>		29d. Date signed (Month, Day, Year) <b>1/10/04</b>
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Spinuzza, D.O. 9733 Healthway Dr. Berlin, MD 21811</b>				
	31. Date filed (Month, Day, Year) <b>JAN 13 2004</b>		32. Registrar's Signature <i>[Signature]</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

DONALD LEROY REEDY

2. Date of Death  
Month Day YearJANUARY !! 2004 2:05AM<sup>M</sup>

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Berlin Nursing and Rehabilitation Center Berlin

4b. City, Town, or Location of Death

4c. County of Death

Worcester

5. Social Security Number

220-20-4692

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

9/11/1927

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

DE

10b. County

Sussex

10c. City, Town or Location

Selbyville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

30-B Blue Teal RD Swan Keys

10f. Zip Code

19975

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

Law Enforcement

17. Father's Name (First, Middle, Last)

Herman Reedy

18. Mother's Name (First, Middle, Maiden Surname)

Mary Burke

19a. Informant's Name/Relationship (Type, Print)

Shawn Reedy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2997 Valley View RD Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cape Henlopen Crematory

Date

1/12/04

20c. Location - City or Town, State

Frankford, DE

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

The Burbage Funeral Home  
108 William St. Berlin, MD 21811

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Bladder Cancer

Due to (or as a consequence of):

b. Metastatic Prostate Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D28769

29d. Date signed (Month, Day, Year)

1/11/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas N. Borodulin, MD Fenwick Island, DE 19944

31. Date filed (Month, Day, Year)

JAN 13 2004

32. Registrar's Signature

State  
RegistrarREEDY, DONALD  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For UNPEND ITEM #23a&27 PER ME G827 1/28/04-JR

Certificate of Death

Reg. No.

2004 01827

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles David Reed</b>			2. Date of Death Month Day Year <b>January 13, 2004</b>			3. Time of Death <b>9:12 A M</b>								
	4a. Facility Name (If not institution, give street and number) <b>2001 Kenny Court</b>			4b. City, Town, or Location of Death <b>Edgewood</b>			4c. County of Death <b>Harford</b>								
Funeral Director	5. Social Security Number <b>219-76-0923</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>45</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 1, 1958</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>						
	10a. State <b>Maryland</b>			10b. County <b>Harford</b>			10c. City, Town or Location <b>Edgewood</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number <b>2001 Kenny Court</b>			10f. Zip Code <b>21040</b>			10g. Citizen of What Country? <b>USA</b>								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>			16b. Kind of Business/Industry								
	17. Father's Name (First, Middle, Last) <b>Charlie Howard Reed</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Betty Jean Honaker</b>											
	19a. Informant's Name/Relationship (Type, Print) <b>Betty J. Reed / Mother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2001 Kenny Ct., Edgewood, MD 21040</b>											
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Grdns 1-16-04</b>			20c. Location - City or Town, State <b>Aberdeen, Maryland</b>								
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009</b>											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>DILATED CARDIOMYOPATHY</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify): 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										26. Place of Death Check only one Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>January 14, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. A. Ron Locke, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>															
31. Date filed (Month, Day, Year) <b>JAN 23 2004</b>			32. Registrar's Signature 												

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01028

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.




To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

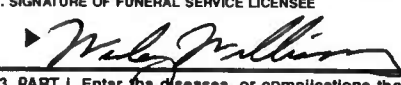


1. Decedent's Name (First, Middle, Last) <b>CHARLES FRANCIS SPALDING</b>		2. Date of Death Month <b>JANUARY</b> Day <b>10</b> Year <b>2004</b>		3. Time of Death <b>9:40A M</b>
4a. Facility Name (If not institution, give street and number) <b>109 HOWARD STREET</b>		4b. City, Town, or Location of Death <b>LA PLATA</b>		4c. County of Death <b>CHARLES</b>
5. Social Security Number <b>218-16-3355</b>	6. Sex <b>XX</b> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>JAN. 7, 1924</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
Usual Residence of Decedent				
10a. State <b>MD</b>	10b. County <b>CHARLES</b>	10c. City, Town or Location <b>LA PLATA</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>109 HOWARD STREET</b>		10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>U. S. A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W.II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BARBER</b>		16b. Kind of Business/Industry <b>BARBERING</b>
17. Father's Name (First, Middle, Last) <b>JAMES CARROLL SPALDING</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARY M. CARROLL</b>		
19a. Informant's Name/Relationship (Type, Print) <b>IRENE SPALDING / WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>109 HOWARD STREET LA PLATA, MARYLAND 20646</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SACRED HEART CEM.</b>		20c. Location - City or Town, State <b>LA PLATA, MARYLAND</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>AREHART-ECHOLS FUNL.HME.P.A. M00641 211 ST.MARY'S AVE. LA PLATA, MD 20646</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Dementia Senile</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Parkinson Disease</b>				Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Venous Insufficiency</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number <b>00001009</b>		29d. Date signed (Month, Day, Year) <b>1-10-04</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HENRY L. BURKE, M.D. 115 LA GRANGE AVENUE LA PLATA, MARYLAND 20646</b>				
31. Date filed (Month, Day, Year) <b>JAN 12 2004</b>		32. Registrar's Signature 		

State Registrar

2004 01029

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Viola Rebecca Stanley</b>				2. DATE OF DEATH MONTH DAY YEAR <b>January 10, 2004</b>		3. TIME OF DEATH <b>7:53 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>214-30-0401</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	8. AGE (In yrs. last birthday) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>June 12, 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>503 Beards Hill Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Aberdeen</b>		9c. COUNTY OF DEATH <b>Hartford</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Hartford</b>		10c. CITY, TOWN OR LOCATION <b>Aberdeen</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>503 Beards Hill Road</b>				10f. ZIP CODE <b>21001</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Her Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Arthur R. Posey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Laura Rebecca Ennis</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Anna Mae Godfrey Daughter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>503 Beards Hill Rd., Aberdeen, Md. 21001</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Trinity Memorial Gardens Jan. 13, 2004</b>		20c. LOCATION — City or Town, State <b>Waldorf, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00668</b>				22. NAME AND ADDRESS OF FACILITY <b>Williams Funeral Home, P.A. 20640 4270 Hawthorne Rd., Indian Head, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular Accident</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>About 3 weeks</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Essential Hypertension</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D15583</b>		29d. DATE SIGNED (Month, Day, Year) <b>January 12, 2004</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MANUEL M. LAZARIN MD 8 Law Street Aberdeen, Maryland 21001</b>							
31. DATE FILED (Month, Day, Year) <b>JAN 13 2004</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01830

Amended

1- For State Registrar item #18, 1/16/04, E.T. WCHD Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ada Schukraft

2. Date of Death

1/9/04

3. Time of Death

10:55 AM

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin, Maryland

4c. County of Death

Worcester County

Funeral  
Director

5. Social Security Number

217 46 0164

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

100

8. Date of Birth

Aug. 19, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Selbyville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

44 Sea Gull Road

10f. Zip Code

19975

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Housekeeping

17. Father's Name (First, Middle, Last)

Frank Frietsch

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lucinda Cheseldine

19a. Informant's Name/Relationship (Type, Print)

Ada May Shipley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

44 Sea Gull Road Selbyville, DE 19975

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cape Henlopen Crem.

Date

1/11/04

20c. Location - City or Town, State

Frankford, DE

21. Signature of Funeral Service Licensee

The Burbage Funeral Home

22. Name and Address of Facility

108 William St. Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of): coronary

b. Atherosclerotic heart disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kristine Griffin, MD

29c. License number

C1-0006795

29d. Date signed (Month, Day, Year)

1-10-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISTINE GRIFFIN, MD.  
1209 Coastal Highway, Fenwick Island, DE 19944

31. Date filed (Month, Day, Year)

JAN 13 2004

32. Registrar's Signature

Brenda B. Sparks

State  
Registrar

ORIGINAL

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

C.H. 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01631

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MELVIN ARTHUR SANDERS</b>				2. Date of Death Month <u>January</u> Day <u>6</u> Year <u>2004</u>		3. Time of Death <u>1733</u> M	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>N. COMICO</b>	
Funeral Director	5. Social Security Number <b>155-32-8583</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2/18/1943</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Pocomoke City</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>2148 Worcester Hwy., Lot #11</b>		10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Labor</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Well Drilling</b>		16b. Kind of Business/Industry		16c. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) <b>Guy Arthur Sanders</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Bernadette McVickers</b>		19a. Informant's Name/Relationship (Type, Print) <b>David P. Sanders (son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>674 Asbury Station Rd., Swedesboro, NJ 08085</b>	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Date <b>1/9/2004</b>		20d. Location - City or Town, State <b>Salisbury, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>Michael A. Dean</i>		22. Name and Address of Facility <b>Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory insufficiency</u> Due to (or as a consequence of): b. <u>End stage chronic obstructive lung disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <u>years</u>	
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Michael R. Buchness M.D.</i>		29c. License number <b>D02038</b>		29d. Date signed (Month, Day, Year) <b>1-6-04</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael P. Buchness MD, 201 Pine Bluff Rd. Salisbury MD 21801</b>	
	31. Date filed (Month, Day, Year) <b>JAN 08 2004</b>		32. Registrar's Signature <i>John H. Spade</i>		33. Registrar's Title <b>State Registrar</b>		34. Registrar's Office <b>C.H. 5+1</b>	

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
Melvin Sanders 155-32-8583  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

AMEND ITEM #8 PER FH G827 1/30/04 Jh

2004 01832

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>David Edward Thomas</b>				2. Date of Death Month <u>January</u> Day <u>9</u> Year <u>2004</u>		3. Time of Death <u>0530</u>	
4a. Facility Name (If not institution, give street and number) <u>7009 Gateway Boulevard</u>				4b. City, Town, or Location of Death <u>District Heights</u>		4c. County of Death <u>Prince George's</u>	
5. Social Security Number <u>218-54-9425</u>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>55</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>3-22-1948</u>	
9. Birthplace (State or Foreign Country) <u>Maryland</u>		10. Usual Residence of Decedent		10a. State <u>Maryland</u>		10b. County <u>Prince George's</u>	
10c. City, Town or Location <u>District Heights</u>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>7009 Gateway Blvd.</u>		10f. Zip Code <u>20747</u>	
10g. Citizen of What Country? <u>U.S.A.</u>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11th</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Equipment Operator</u>		16b. Kind of Business/Industry <u>Dept. of Public Works</u>	
17. Father's Name (First, Middle, Last) <u>Joseph L. Thomas</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Lillian B. Tucker</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Ling Swee Thomas (Wife)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7009 Gateway Blvd. District Heights, MD 20747</u>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Ft. Lincoln Cemetery</u>		20c. Location - City or Town, State <u>Brentwood, Maryland</u>		20d. Date <u>Jan. 13, 2004</u>	
21. Signature of Funeral Service Licensee <u>SK S. Smith M00542</u>				22. Name and Address of Facility <u>Lee Funeral Home, Inc.</u> <u>6633 Old Alexandria Ferry Road Clinton, MD</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Hypertensive Heart Disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>Salvador S. Lopez DO</u>			
29c. License number <u>H0055927</u>				29d. Date signed (Month, Day, Year) <u>January 10, 2004</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Salvador S. Lopez 3001 Hospital Drive, Chevy Chase, Maryland</u>							
31. Date filed (Month, Day, Year) <u>JAN 15 2004</u>				32. Registrar's Signature <u>Ann B. Smith</u>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DBID

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND #8, 23a-c, 29d PER PHY 1/14/04 **Certificate of Death**

Reg. No.

2004 01033

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1. Decedent's Name (First, Middle, Last) <b>LEWIS E. TWINE</b>		2. Date of Death Month <b>1</b> Day <b>10</b> Year <b>2004</b>		3. Time of Death <b>11:24AM</b>	
4a. Facility Name (If not institution, give street and number) <b>University of Maryland Med. Ctr.</b>		4b. City, Town, or Location of Death <b>Baltimore, MD</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>224-36-8072</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>73</b> Yrs.	
8. Date of Birth <b>9/12/30</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Lusby</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>657 Running Fox Road</b>		10f. Zip Code <b>20657</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>		16b. Kind of Business/Industry <b>Automotive</b>	
17. Father's Name (First, Middle, Last) <b>Robert Twine</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Twine</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Shirley Wilson-daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>657 Running Fox Road, Lusby, MD 20657</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Memorial Gdns.</b>		20c. Location - City or Town, State <b>01-14-2004 Waldorf, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Tack A. Wilson</b>		22. Name and Address of Facility <b>Huntt Funeral Home P.O. Box 156, Waldorf, MD 20604-0156</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CARDIO RESPIRATORY ARREST</b>		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)	
23d. Date of delivery Month Day Year					
23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Myeloproliferative Disorder s/p Small Bowel Resection - Colonic mucous fistula</b>		23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
23g. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23h. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>James H. [Signature] RESIDENT</b>		29c. License number <b>CA A82580</b>		29d. Date signed (Month, Day, Year) <b>JAN. 13, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kachory Saechea, MD, University of Maryland Med. Ctr. Baltimore, MD 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 14 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01834

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Lorna Thompson</b>		2. Date of Death Month <b>January</b> Day <b>10</b> Year <b>2004</b>		3. Time of Death <b>1:10 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Charles County Nursing and Rehab Ctr.</b>		4b. City, Town, or Location of Death <b>LaPlata</b>		4c. County of Death <b>Charles</b>	
5. Social Security Number <b>192-24-3773</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>March 2, 1928</b>	9. Birthplace (State or Foreign Country) <b>England</b>	
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Charles</b>	10c. City, Town or Location <b>Waldorf</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>12000 Pierce Road</b>		10f. Zip Code <b>20601</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>sales</b>		16b. Kind of Business/Industry <b>furniture</b>	
17. Father's Name (First, Middle, Last) <b>Joseph White</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Vera Jones</b>		
19a. Informant's Name/Relationship (Type, Print) <b>John Thompson-son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12000 Pierce Rd., Waldorf, MD 20601</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Huntt Crematory</b>		20c. Location - City or Town, State <b>01-12-2004 Waldorf, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Jack A. Wilson</b> M01246		22. Name and Address of Facility <b>Huntt Funeral Home P.O. Box 156, Waldorf, MD 20604-0156</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cancer lung with metastasis</b> Due to (or as a consequence of): a. <b>Cancer lung with metastasis</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>J. H. ...</b>		29c. License number <b>00056949</b>		29d. Date signed (Month, Day, Year) <b>1/12/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KARAKSHI BAIG R.D. 6620 CRAIN HWY, STE 102, LA PLATA, MD - 20646</b>					
31. Date filed (Month, Day, Year) <b>JAN 12 2004</b>		32. Registrar's Signature <b>...</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01835

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Judith Gale Waddell</b>			2. Date of Death Month <b>January</b> Day <b>11</b> , Year <b>2004</b>		3. Time of Death <b>12:55A</b>	
	4a. Facility Name (If not institution, give street and number) <b>Joseph Ritchie Hospice</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>577-58-2222</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>May 13, 1944</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Clinton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>3505 Manis Road</b>			10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Operator</b>		16b. Kind of Business/Industry <b>US Postal Service</b>		
	17. Father's Name (First, Middle, Last) <b>Hurley Stoots</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Murial Hart</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Edgar T. Waddell, Sr. (Husband)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3505 Manis Road Clinton, Maryland 20735</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		Date <b>Jan. 13, 2004</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>
	21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. non-small cell carcinoma of lung with mets</b>						
	23b. Part II. Enter the immediate cause (Final disease or condition resulting in death) and the underlying cause (Disease or injury that initiated events resulting in death) Last <b>b. 18 mo</b>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D13012</b>		29d. Date signed (Month, Day, Year) <b>11/11/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type/Print) <b>John Payne 4311 Underwood Rd Baltimore, MD 21218</b>							
31. Date filed (Month, Day, Year) <b>JAN 15 2004</b>		32. Registrar's Signature <b>[Signature]</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01836

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>LOUISE HAZEL WARRINGTON</b>		2. Date of Death Month <b>1</b> Day <b>8</b> Year <b>2004</b>		3. Time of Death <b>6:00 A M</b>	
4a. Facility Name (If not institution, give street and number) <b>402 South Morris St.</b>		4b. City, Town, or Location of Death <b>Snow Hill</b>		4c. County of Death <b>Worcester</b>	
5. Social Security Number <b>217-14-8412</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>11/6/1915</b>		9. Birthplace (State or Foreign Country) <b>MD</b>			
10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Snow Hill</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>402 South Morris St.</b>		10f. Zip Code <b>21863</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>		16b. Kind of Business/Industry <b>Shirt Factory</b>		17. Father's Name (First, Middle, Last) <b>William K. Powell</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Della (Unknown)</b>		19a. Informant's Name/Relationship (Type, Print) <b>Elaine Mason</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>402 South Morris St. Snow Hill, MD 21863</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cape Henlopen Crematory</b>		20c. Location - City or Town, State <b>Frankford, DE</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>The Burbage Funeral Home 208 W. Federal St. Snow Hill, MD 21863</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>cardiac arrhythmia</b>	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hypothyroidism</b> <b>chronic gastrointestinal bleeding</b>		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of Certifier <i>[Signature]</i>		29c. License number <b>03085</b>		29d. Date signed (Month, Day, Year) <b>1/8/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles B. Silva, Jr. mms 1346 S. Division St suite 103 Salisbury md 21804</b>		31. Date filed (Month, Day, Year) <b>JAN 09 2004</b>		32. Registrar's Signature <i>[Signature]</i>	

C.H.2

State  
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01837

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Shirley Wright</b>		2. Date of Death Month <b>January</b> Day <b>9</b> Year <b>2004</b>		3. Time of Death <b>3:07PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Casey House</b>		4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>395-28-1192</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>June 16, 1932</b>		9. Birthplace (State or Foreign Country) <b>Wisconsin</b>
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Olney</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>17516 Princess Anne Drive</b>		10f. Zip Code <b>20832</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Professor</b>		16b. Kind of Business/Industry <b>University</b>	
17. Father's Name (First, Middle, Last) <b>John Minkewitz</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Hite</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Karen Horneij Brown/ niece</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>296 Freyer Drive NE, Marietta, GA 30060</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee  <b>MO1251</b>		22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>End Stage Cardiomyopathy</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>6 months</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>Amyloidosis</b> Due to (or as a consequence of):		<b>1 year</b>	
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>00041218</b>		29d. Date signed (Month, Day, Year) <b>01/09/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles Harrison M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855</b>					
31. Date filed (Month, Day, Year) <b>JAN 14 2004</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01838

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Earl Anderson, Sr.				2. Date of Death Month Day Year January 23, 2004		3. Time of Death 11:20 AM	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-46-4479		6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F XX		7. Age (in yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) Sept 27, 1946	
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1337 W. 42nd Street		10f. Zip Code 21211		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Viet Nam		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Engineer		16b. Kind of Business/Industry Deutsche Bank		17. Father's Name (First, Middle, Last) Donald Anderson	
	18. Mother's Name (First, Middle, Maiden Surname) Virginia Herndon		19a. Informant's Name/Relationship (Type, Print) Margaret Anderson Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1337 W. 42nd Street Baltimore, Maryland 21211		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Date 1/28/2004		20d. Location - City or Town, State Parkville, Maryland		21. Signature of Funeral Service Licensee Lynn B. Henss	
	22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of): b. Acute Respiratory Distress Syndrome Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 4 days 3 days		23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28c. Injury at Work? 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) 29b. Signature and title of certifier Nichols MD		29c. License number A04176435 N13114		29d. Date signed (Month, Day, Year) January 23, 2004		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University Parkway Baltimore MD 21218	
	31. Date filed (Month, Day, Year) JAN 27 2004		32. Registrar's Signature James B. Sparks					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68750,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01839

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Horace Franklin Abee</b>				2. Date of Death Month <b>January</b> Day <b>22</b> Year <b>2004</b>		3. Time of Death <b>11:50 P<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>7 Dovetail Lane</b>				4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>237-24-9991</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 25, 1923</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7 Dovetail Lane</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1943-</b> If Yes, Give Year or Dates: <b>1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Brick Mason</b>		16b. Kind of Business/Industry <b>Steel Plant</b>				
17. Father's Name (First, Middle, Last) <b>Esley Abee</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Mae Shook</b>		19a. Informant's Name/Relationship (Type, Print) <b>June Abee (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7 Dovetail Lane Essex, Maryland 21221</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory Inc</b>		Date <b>Jan. 24, 2004</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Susan W. Bule</b>		22. Name and Address of Facility <b>Bruzdinski Funeral Home PA</b>		1407 Old Eastern Avenue		Essex, Maryland 21221		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Respiratory Insufficiency</b> <b>Chronic Obstructive Pulmonary Dx</b>		Approximate Interval Between Onset and Death <b>6 years</b> <b>6 years</b>						
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b> <b>Hypertension</b>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>John D.O.</b>		29c. License number <b>H35593</b>		29d. Date signed (Month, Day, Year) <b>1/23/2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR JOHN J. LOTT</b>		1124 Mace Ave, Baltimore, MD 21221						
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01860

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Henry William Bahne, JR.</b>		2. Date of Death Month <b>JAN.</b> Day <b>25</b> Year <b>2004</b>		3. Time of Death <b>1:00 P.M.</b>
4a. Facility Name (If not institution, give street and number) <b>Gilchrist Center</b>		4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>Baltimore</b>
5. Social Security Number <b>086-32-5779</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>10-5-40</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
Usual Residence of Decedent				
10a. State <b>MD</b>	10b. County <b>HARFORD</b>	10c. City, Town or Location <b>Bel Air</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>408 Mawser Dr.</b>		10f. Zip Code <b>21015</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Vice President Counseling Services</b>		16b. Kind of Business/Industry <b>Consumer Credit</b>		
17. Father's Name (First, Middle, Last) <b>Henry William Bahne, SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ellen Davis</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Donna Jean Bahne-wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>408 Mawser Dr, Bel Air, MD 21015</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>1-28-04 Churchville MD</b>
21. Signature of Funeral Service Licensee <b>Kimberly A. Jurek</b>		22. Name and Address of Facility <b>EVANS FUNERAL CHAPEL-BELAIR, PA. 21050</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lung cancer</b>				Approximate Interval Between Onset and Death <b>month</b>
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				23e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
24. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>		
26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		27. Date of Injury (Month, Day Year)		27b. Time of Injury <b>M</b>
27c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		27d. Describe how injury occurred		
27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		27f. Location (Street and Number or Rural Route Number, City or Town, State)		
28a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
28b. Signature and title of certifier <b>W.A. Riley, MD</b>		28c. License number <b>025205</b>		28d. Date signed (Month, Day, Year) <b>January 25, 2004</b>
29. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A. Riley, G.B.M.C. 6701 N. Charles St. Balto. Md 21204</b>				
30. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		31. Registrar's Signature <b>[Signature]</b>		

**State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01842

1- For State Registrar

Certificate of Death

Reg. No.

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH H. BONTHRON		2. Date of Death Month Day Year JANUARY 25, 2004		3. Time of Death 1:50 AM
	4a. Facility Name (If not institution, give street and number) GILCHRIST CENTER		4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 212-18-8937	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	8. Date of Birth (Month, Day, Year) NOVEMBER 28, 1921	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County BALTIMORE	10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 6825 CAMPFIELD ROAD, APT 5C		10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK		16b. Kind of Business/Industry TELEPHONE		
	17. Father's Name (First, Middle, Last) RICHARD R. HEATH		18. Mother's Name (First, Middle, Maiden Surname) MARGARET E. JONES		
	19a. Informant's Name/Relationship (Type, Print) LYNN CASEBERE / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9325 E. QUARRY TRAIL, SCOTTSDALE, ARIZONA		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Date MOST HOLY REDEMPTION CEMETERY JAN 30 2004		
Physician / Medical Examiner	20c. Location - City or Town, State BALTIMORE, MARYLAND		21. Signature of Funeral Service Licensee Kimberly J. Zierke		
	22. Name and Address of Facility EVANS FUNERAL CHAPEL 8800 HARFORD RD, PARKVILLE, MD 21234		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ischemic cardiomyopathy		
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. If female, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		
	23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
State Registrar	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier W.A. Riley, M.D.		
	29c. License number D25225		29d. Date signed (Month, Day, Year) JANUARY 25, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley, M.D. 6701 N. Charles St. Balto, MD 21204					
31. Date filed (Month, Day, Year) JAN 27 2004		32. Registrar's Signature [Signature]			



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 012043

1- For State Registrar

Certificate of Death

Reg. No.

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Florence L. Bain</b>		2. Date of Death Month <b>01</b> - Day <b>23</b> - Year <b>04</b>		3. Time of Death <b>10:20 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>		4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>219-28-4479</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Aug. 25, 1932</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Dundalk</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>3511 Loganview Drive</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Meat Wrapper</b>		16b. Kind of Business/Industry <b>Grocery Store</b>		
	17. Father's Name (First, Middle, Last) <b>Joseph Weber</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Brannock</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Karl Bain (husband)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3511 Loganview Drive Baltimore, Md 21222</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		20c. Location - City or Town, State <b>1/27/04 Baltimore, Md.</b>
Physician / Medical Examiner	21. Signature of Funeral Service Licensee <b>Robert J. Dodach, Jr.</b>		22. Name and Address of Facility <b>Kaczorowski Funeral Home, PA 1201 Dundalk Ave Baltimore, Md. 21222</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Respiratory Failure</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. <b>Sepsis</b> Due to (or as a consequence of): d. <b>Cirrhosis</b>				Approximate Interval Between Onset and Death
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sub-acute bacterial peritonitis</b> <b>Renal failure</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>H-86477</b>		29d. Date signed (Month, Day, Year) <b>01-23-04</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Kenneth McDowell 9000 Franklin Square Drive Baltimore, Md 21237</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>[Signature]</b>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01844

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Ruth Inez Berends</b>		2. Date of Death Month <b>January</b> Day <b>22</b> Year <b>2004</b>		3. Time of Death <b>11:10 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>		4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>411-48-3997</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>March 25, 1932</b>		9. Birthplace (State or Foreign Country) <b>Tennessee</b>			
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4107 Slater Avenue</b>		10f. Zip Code <b>21236</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>John Collins</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Range</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Wesley Berends (son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1718 Morse Rd, Forest Hill, MD 21050</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Brian A. Miller</b>		22. Name and Address of Facility <b>Schimunek Funeral Homes</b> <b>9705 Belair Rd., Baltimore, MD 21236</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. <b>Lung Cancer</b> Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b> <b>Anemia</b>					
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Dr. Glenn Meining</b> MD.		29c. License number <b>D0056477</b>		29d. Date signed (Month, Day, Year) <b>1/22/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Glenn Meining 9000 Franklin Square Drive, Baltimore, Maryland 21237</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>					
32. Registrar's Signature <b>Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01045

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>James Barrow</u>		2. Date of Death Month <u>January</u> Day <u>21</u> Year <u>2004</u>		3. Time of Death <u>425 A M</u>
	4a. Facility Name (If not institution, give street and number) <u>Northwest Hospital Center</u>		4b. City, Town, or Location of Death <u>Randallstown</u>		4c. County of Death <u>Baltimore</u>
Funeral Director	5. Social Security Number <u>216-28-6612</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>73</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>Nov 15, 1930</u>	
	9. Birthplace (State or Foreign Country) <u>Maryland</u>				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <u>MD</u>	10b. County <u>Baltimore</u>	10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <u>6300 Liberty Road APT 5</u>		10f. Zip Code <u>21207</u>		10g. Citizen of What Country? <u>U. S. A.</u>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <u>White</u>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>3</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Lineman</u>		16b. Kind of Business/Industry <u>Tele Communications</u>
	17. Father's Name (First, Middle, Last) <u>James Lewis Barrow</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Virginia Richards</u>		
	19a. Informant's Name/Relationship (Type, Print) <u>Jeffrey Barrow</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2643 Coxneck Road, Chester, MD. 21619</u>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery</u>		20c. Location - City or Town, State <u>01/24/04 Woodlawn, Md. 21207</u>
	21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Loring Byers Funeral Directors Inc</u> <u>8728 Liberty Road, Randallstown, Md. 21133-4784</u>		
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>Small cell lung cancer</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <u>[Signature] MD</u>		29c. License number <u>D0060567</u>		29d. Date signed (Month, Day, Year) <u>January 21, 2004</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Manjoy Mojia Northwest Hospital Old Court Road Randallstown, Maryland</u>					
31. Date filed (Month, Day, Year) <u>JAN 27 2004</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01846

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mildred Bynion</b>				2. Date of Death Month <b>January</b> Day <b>26</b> Year <b>2004</b>		3. Time of Death <b>7:03</b> M	
	4a. Facility Name (If not institution, give street and number) <b>Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-22-1157</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 9, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>Md.</b>		10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10a. Street and Number <b>1611 Pumphrey St.</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 yrs.</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>		16b. Kind of Business/Industry <b>Clothing</b>			
	17. Father's Name (First, Middle, Last) <b>Herbert Bynion</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Kowadji</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Dolores Hamel sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1611 Pumphrey St. Baltimore Md. 21224</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus</b>		Date <b>Jan. 29, 2004</b>		20c. Location - City or Town, State <b>Dundalk</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Connolly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pancreatic Cancer</b>							Approximate Interval Between Onset and Death <b>2 weeks</b>
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
29c. License number <b>76706</b>		29d. Date signed (Month, Day, Year) <b>January 26 2004</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Eric Howell MD 4940 Eastern Avenue, Baltimore, MD 21224</b>								
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

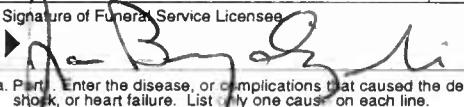

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01817

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Diann Marie Bialozynski</b>						2. Date of Death Month <b>January</b> Day <b>23</b> Year <b>2004</b>		3. Time of Death <b>6:10 a M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Center for Hospice</b>						4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
<b>Funeral Director</b>	5. Social Security Number <b>212 46 5930</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 6, 1946</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>614 Oakdean Road</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>			16b. Kind of Business/Industry <b>Accounting</b>			
17. Father's Name (First, Middle, Last) <b>Charles Funk</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Jelinek</b>				
19a. Informant's Name/Relationship (Type, Print) <b>William Bialozynski (husband)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>614 Oakdean Road Middle River Maryland 21220</b>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory Inc</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		20d. Date <b>1/26/2004</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Bruzdinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lung Cancer</b>										
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown										
23d. Date of delivery Month Day Year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Dr. Anthony Riley, MD</b>										
29c. License number <b>D25205</b>										
29d. Date signed (Month, Day, Year) <b>JANUARY 23, 2004</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A. Riley GBMC 6701 N. Charles St. Balto. MD 21204</b>										
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>										
32. Registrar's Signature 										



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>MATILDA BERMAN</b>		2. Date of Death Month <b>JANUARY</b> Day <b>23</b> , Year <b>2004</b>		3. Time of Death <b>3:40 A M</b>	
4a. Facility Name (If not institution, give street and number) <b>RUXTON PIKESVILLE NURSING HOME</b>		4b. City, Town, or Location of Death <b>PIKESVILLE</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>213-44-9622</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR. 26, 1912</b>
Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>MD</b>			
10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3014 ROMARIC COURT #F</b>		10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESWOMAN</b>	
16b. Kind of Business/Industry <b>RETAIL - HATS</b>		17. Father's Name (First, Middle, Last) <b>BENJAMIN MAZUR</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARY LILLIAN ARNSTEIN</b>	
19a. Informant's Name/Relationship (Type, Print) <b>JACK BERMAN / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3014 ROMARIC COURT #F - BALTIMORE, MD 21209</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW YOUNG MEN</b>		20c. Location - City or Town, State <b>WOODLAWN, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiomyopathy</b>					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Duodenal PVP</b>					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)					
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D27569</b>		29d. Date signed (Month, Day, Year) <b>11/23/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ellen Hetherman 1838 Greene Tree Rd 21208</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01849

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Anna P. CRAWFORD</i>			2. Date of Death Month <i>Jan</i> Day <i>21</i> Year <i>2004</i>		3. Time of Death <i>9:35P</i> M	
	4a. Facility Name (If not institution, give street and number) <i>Quail Run Assisted Living Bel Air</i>			4b. City, Town, or Location of Death <i>BEL AIR</i>		4c. County of Death <i>HARFORD</i>	
Funeral Director	5. Social Security Number <i>830-24-1130</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>75</i> Yrs.	8. Date of Birth Month <i>8</i> Day <i>7</i> Year <i>28</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <i>MD</i>		10b. County <i>HARFORD</i>		10c. City, Town or Location <i>JARRETTSVILLE</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <i>3528 Glen Oak Dr.</i>			10f. Zip Code <i>21084</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Deli Manager</i>		16b. Kind of Business/Industry <i>Acme Markets</i>	
	17. Father's Name (First, Middle, Last) <i>Hugo Pomponi</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Ida Ricci</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Linda Miller</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3528 Glen Oak Dr., JARRETTSVILLE MD 21084</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>PARKWOOD CEMETERY</i>		20c. Location - City or Town, State <i>2-2-2004 PARKVILLE, MD</i>		
	21. Signature of Funeral Service Licensee <i>Kimberly L. Purdy</i>			22. Name and Address of Facility <i>BALTIMORE MD 21234 EVANS FUNERAL CHAPEL, 8800 HARFORD RD.</i>			
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Alzheimer's Dementia</i>						Approximate Interval Between Onset and Death <i>2 years</i>
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Assisted Living Facility</i>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>N. Deshpande MD</i>			29c. License number <i>546082</i>		29d. Date signed (Month, Day, Year) <i>1/23/2004</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>NEETA DESHPANDE, M.D. 9105 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237</i>							
31. Date filed (Month, Day, Year) <i>JAN 27 2004</i>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01050

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Florence D. Crane</b>		2. Date of Death Month <b>January</b> Day <b>24</b> Year <b>2004</b>		3. Time of Death <b>10:05 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>		4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore Co.</b>
Funeral Director	5. Social Security Number <b>215-10-9706</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Feb. 16, 1911</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Baltimore Co.</b>	10c. City, Town or Location <b>Timonium</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>2300 Dulaney Valley Rd.</b>		10f. Zip Code <b>21093</b>	10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Telephone Operator</b>		16b. Kind of Business/Industry <b>Hechts</b>
	17. Father's Name (First, Middle, Last) <b>Alexander Dominick</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Casimira Brokins</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mr. David Dominick (nephew)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1206 Regester Ave. Balto. MD 21239</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gar.</b>		20c. Location - City or Town, State <b>Jan. 28, 2004 Timonium, MD</b>
	21. Signature of Funeral Service Licensee <b>Jeffrey L. Gandy Sr.</b>		22. Name and Address of Facility <b>Peacetal Alternatives Funeral + Cremation Center 2325 York Rd. Timonium, MD 21093</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Ovarian Cancer</b>				
	23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Ernestine Wnght MD</b>					
29c. License number <b>D52740</b>					
29d. Date signed (Month, Day, Year) <b>January 26, 2004</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ernestine Wnght, 2300 Dulaney Valley Road, Timonium MD 21093</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>					
32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01851

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Norman E. Carlson				2. Date of Death Month Day Year January 24 2004		3. Time of Death 4:41 P M	
	4a. Facility Name (If not institution, give street and number) Charlestown Care Center				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 022 07 5482		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Nov 25, 1914	
	9. Birthplace (State or Foreign Country) Massachusetts		10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 719 Maiden Choice Lane HR533		10f. Zip Code 21228		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fire Protection Engineer		16b. Kind of Business/Industry Fire Protection				
17. Father's Name (First, Middle, Last) Carl Emil Carlson				18. Mother's Name (First, Middle, Maiden Surname) Emily Marianna Johansson				
19a. Informant's Name/Relationship (Type, Print) Anita K. Carlson/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Lane HR533 Catonsville, MD 21228				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 1-26-2004		20c. Location - City or Town, State Catonsville, MD		
21. Signature of Funeral Service Licensee M01044 Sara Collins-Wife		22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. gastrointestinal bleed Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death hours								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA		Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Myra M. Carpenter		29c. License number D 30989		29d. Date signed (Month, Day, Year) January 25, 2004				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myra M. Carpenter MD 711 Maiden Choice Ln Catonsville MD								
31. Date filed (Month, Day, Year) JAN 27 2004		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial-Transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01852

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Peter C. Collins</b>			2. Date of Death Month Day Year <b>January 21, 2004</b>			3. Time of Death M <b>6:46 p</b>				
	4a. Facility Name (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>				
Funeral Director	5. Social Security Number <b>394-18-7983</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 7 1923</b>		9. Birthplace (State or Foreign Country) <b>Wisconsin</b>		
	Usual Residence of Decedent			10a. State <b>MD</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Timonium</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number <b>404 Ivy Church Rd.</b>			10f. Zip Code <b>21093</b>			10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>'43-'46</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Actor</b>			16b. Kind of Business/Industry <b>Entertainment</b>					
17. Father's Name (First, Middle, Last) <b>Dr. Clarence Collins</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Phoebe Shierk</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Stacy Collins O'Connor/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12850 Stone Eagle Rd., Phoenix, MD 21131</b>								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Balto. Wash. Crematory</b>			20c. Location - City or Town, State <b>Laurel, MD</b>					
21. Signature of Funeral Service Director <b>Michael J. Flagle</b>			22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiac Failure</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):			23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, history of carcinoma of lung, cardiac valvular disease, chronic obstructed pulmonary disease</b>			24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>Steven H. Richmond</b>			29c. License number <b>D30206</b>			29d. Date signed (Month, Day, Year) <b>January 23, 2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Steven H. Richmond, M.D., GBMC, 6701 N. Charles St., Towson, MD 21204</b>			31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>			32. Registrar's Signature <b>Steven H. Richmond</b>					



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALFRED

CICERE

2. Date of Death

Month Day Year  
JANUARY 22 2004

3. Time of Death

2145 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-22-1119

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
March 6, 1928

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8204 Watersedge Rd.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7 yrs.

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Shearman

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Gerlamo Cicere

18. Mother's Name (First, Middle, Maiden Surname)

Concetta Monaco

19a. Informant's Name/Relationship (Type, Print)

Grace Cicere wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8204 Watersedge Rd. Dundalk Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest V.A. Cem.

Date

Jan. 27  
2004

20c. Location - City or Town, State

Owings Mills

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk  
7110 Sollers Point Rd. 2122223a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

C1 SPINAL CORD LESION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death  
24 HOURS

24 HOURS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSONS DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Julie G Reed MD

29c. License number

RES-100

29d. Date signed (Month, Day, Year)

JANUARY 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANN REED JOHNS HOPKINS HOSPITAL TOWER 110 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph Thomas Casteel

2. Date of Death

January 24, 2004

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

Vantage House/ 5400 Vantage Point Road

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

259-16-2284

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

NOV 11, 1918

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5400 Vantage Point Road #1113

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1941-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)

Executive Assistant to the Chief Medical Director

16b. Kind of Business/Industry

Veterans Administration

17. Father's Name (First, Middle, Last)

Joseph Casteel

18. Mother's Name (First, Middle, Maiden Surname)

Vesta Fuller

19a. Informant's Name/Relationship (Type, Print)

Elva L. Casteel/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5400 Vantage Point #1113 Columbia, MD 21044

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

1-26-04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.  
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

pneumonia

Approximate Interval Between Onset and Death

1 month

b. Due to (or as a consequence of):

chronic obstructive lung disease

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

insulin dependent diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gary Mills MD

29c. License number

026621

29d. Date signed (Month, Day, Year)

January 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARY MILLS MD, 10700 Charter Drive, Columbia, MD

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Doris Eleanor Carlson</b>				2. Date of Death Month <b>January</b> Day <b>25</b> Year <b>2004</b>		3. Time of Death <b>8:35 P M</b>	
4a. Facility Name (If not institution, give street and number) <b>Future Care Chesapeake</b>				4b. City, Town, or Location of Death <b>Arnold</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>540-01-9421</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC 26, 1917</b>	
9. Birthplace (State or Foreign Country) <b>Oregon</b>							
10a. State <b>Maryland</b>				10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number <b>5 St. Andrews Road</b>				10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Clarence Elston</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Bones</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Richard Carlson/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 St. Andrews Road Severna Park, MD 21146</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		Date <b>1-26-04</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <b>Edward A. Gregorchik</b>				22. Name and Address of Facility <b>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</b>			

To Be Completed by Funeral Director

permat. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death	
a. <b>Brain stem stroke, recurrent</b>				<b>7 months</b>	
b. <b>Atrial Fibrillation</b>				<b>months</b>	
c. <b>Hypertension</b>				<b>years</b>	
d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Deep vein thrombosis, arterial embolism to iliac bifurcation</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier		29c. License number <b>D41955</b>		29d. Date signed (Month, Day, Year) <b>1-26-04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rebecca Elton MD 8601 Veterans Highway #204 Millersville MD 21108</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gloria Dicus		2. Date of Death Month January Day 23, Year 2004		3. Time of Death 5:15A M
	4a. Facility Name (If not institution, give street and number) 4669 Falls Road Manor Care Park Roland		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 213-36-5509	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	8. Date of Birth (Month, Day, Year) Feb. 11, 1936	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County n/a	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 1009 Rectory Lane		10f. Zip Code 21211		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry Restaurant		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Frederick Davis		18. Mother's Name (First, Middle, Maiden Surname) Lillian Schley		
	19a. Informant's Name/Relationship (Type, Print) Raymond Dicus Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 Rectory Lane Baltimore, Maryland 21211		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) Baltimore-Washington Crematory		20c. Location - City or Town, State 1/27/04 Laurel, Maryland
	21. Signature of Funeral Service Licensee Lynn B. Heuss		22. Name and Address of Facility Burgee-Hanss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, MD 21211		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Endometrial cancer with metastases Due to (or as a consequence of): b. Atrial fibrillation and flutter Due to (or as a consequence of): c. Status post total abd hysterectomy Due to (or as a consequence of): d. Status Bilateral Salpingo oophorectomy				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bilateral lower extremities edema Hypertension Hyperthyroidism					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27a. Date of Injury (Month, Day, Year)	
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier J. A. H. MD		29c. License number D 31464		29d. Date signed (Month, Day, Year) 11/23/04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOAISS A. HASTON MD, 821 N. Eutaw St Suite 308 Balt. MD 21201					
31. Date filed (Month, Day, Year) JAN 27 2004		32. Registrar's Signature B. Sparks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01857

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Elmer Dearchs

2. Date of Death

January 23, 2004

3. Time of Death

10:06 AM

4a. Facility Name (If not institution, give street and number)

St. Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

410-14-0038

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR 12, 1921

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1403 Malvern Avenue

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNK.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Building Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Claude Elmer Dearchs

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Hofius

19a. Informant's Name/Relationship (Type, Print)

Raymond A. Dearchs/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1403 Malvern Avenue Towson, MD 21204

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

1-24-04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DILATED CARDIOMYOPATHY

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

10 yrs

c. CHRONIC ANEMIA

Due to (or as a consequence of):

3 yrs

d. RENAL INSUFFICIENCY

Due to (or as a consequence of):

3 yrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

17y PNEUMONIA

ATRIAL FIBRILLATION

OBSTRUCTIVE SLEEP APNEA

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vincent A. DiPietro

29c. License number

D28812

29d. Date signed (Month, Day, Year)

January 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vincent A. DiPietro, MD 7801 York Road, Suite 102 Towson, MD 21204

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01050

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Helena

2. Date of Death

January 24, 2004

3. Time of Death

9:50 A M

4a. Facility Name (If not institution, give street and number)

2953 Marnat Rd. Apt. A

4b. City, Town, or Location of Death

Pikesville

4c. County of Death

Baltimore

5. Social Security Number

213-52-3141

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 5, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2953 Marnat Rd. Apt. A.

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

10th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

childcare Provider

16b. Kind of Business/Industry

childcare

17. Father's Name (First, Middle, Last)

William Dorsey

18. Mother's Name (First, Middle, Maiden Surname)

Lola Myers

19a. Informant's Name/Relationship (Type, Print)

Angela Ebb - niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 N. Tremont Rd. Balto., MD 21229

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

1-29-04

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gary P. March 270 Fredhillon Pass Balto, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Crossan O'Donovan, MD

29c. License number

D0007632

29d. Date signed (Month, Day, Year)

January 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. CROSSAN O'DONOVAN, MD. 2112 DUNDALK AVE BALTO MD 21222

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01059

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna B. Dancy			2. Date of Death Month Day Year January 23, 2004 January 25, 2004		3. Time of Death 10:25 PM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 190-32-2574	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	8. Date of Birth (Month, Day, Year) March 3, 1908	9. Birthplace (State or Foreign Country) PA		
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Glen Arm		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 11630 Glen Arm Road			10f. Zip Code 21057		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
	14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Education		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Noah Buck			18. Mother's Name (First, Middle, Maiden Surname) Laura May Porter			
	19a. Informant's Name/Relationship (Type, Print) Virginia Dickie/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Leeswood Road Bel Air, MD. 21014			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Morris Cemetery		20c. Location - City or Town, State Phoenixville, PA		
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. chronic obstructive lung disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						
23b. If female: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure end-stage renal disease							
23d. Date of delivery Month Day Year							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined							
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature] 29c. License number D25205 29d. Date signed (Month, Day, Year) January 24, 2004							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W A Riley G BMC 6701 N. Charles St. Balto. md 21204							
31. Date filed (Month, Day, Year) JAN 27 2004 32. Registrar's Signature [Signature]							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01860

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Helen Doles</b>		2. Date of Death Month <b>01</b> Day <b>17</b> Year <b>04</b>		3. Time of Death <b>11:30 PM</b>
4a. Facility Name (If not institution, give street and number) <b>Blue Point Nursing Rehab center</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>232 56 8421</b>	6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>DEC. 6, 1929</b>	9. Birthplace (State or Foreign Country) <b>N. CAROLINA</b>
Usual Residence of Decedent				
10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>3610 DUVAL AVE</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1</b> Yes <b>2</b> No
14. Race - American Indian, Black, White, etc. <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) <b>11th grade</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housekeeper</b>		16b. Kind of Business/Industry <b>Baltimore City</b>		
17. Father's Name (First, Middle, Last) <b>Frank Murphy</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>CORRINA MAY WEST</b>		
19a. Informant's Name/Relationship (Type, Print) <b>LENA MARSHALL / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4329 GREENHILL AVE Baltimore, Maryland 21206</b>		
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Swiss Ridge Cemetery</b>		20c. Location - City or Town, State <b>Pikesville, Maryland</b>
21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>CHATHAM - Northwood Home 5240 KESTER BLVD BALTIMORE, MD 21215</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Atherosclerotic Cardiovascular disease</b> Due to (or as a consequence of): b. <b>End stage Renal Disease</b> Due to (or as a consequence of): c. <b>Diabetes Mellitus</b> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No				24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)		
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <b>Amrutan M Naem MD</b>		29c. License number <b>D 15503</b>		29d. Date signed (Month, Day, Year) <b>January 18, 2004</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AMRUTAN M NAEM 501 Dolphin Street, Balto, MD 21217</b>				
31. Date filed (Month, Day, Year) <b>JAN 26 2004</b>		32. Registrar's Signature <b>[Signature]</b>		

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death  
Reg. No. 2004 01061

1. Decedent's Name (First, Middle, Last) <b>Stephen D. Geyer</b>		2. Date of Death Month Day Year <b>JANUARY 23, 2004</b>		3. Time of Death <b>8:34 P M</b>	
4a. Facility Name (If not institution, give street and number) <b>8418 NUNLEY DR</b>		4b. City, Town, or Location of Death <b>PARKVILLE</b>		4c. County of Death <b>BALTIMORE CO</b>	
5. Social Security Number <b>219-50-9918</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>50</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>4-1-53</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>PARKVILLE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8418 Nunley Dr. Apt. B</b>		10f. Zip Code <b>21234</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>		16b. Kind of Business/Industry <b>Insurance</b>		17. Father's Name (First, Middle, Last) <b>Adam J. Geyer, Jr.</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>MARTHA I. MEISE</b>		19a. Informant's Name/Relationship (Type, Print) <b>Adam J. Geyer, III</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 Prospect St., Dedham, MA 02026</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>EVANS FUNERAL CHAPEL</b>		20c. Location - City or Town, State <b>1-25-04. FOREST HILL, MD</b>	
21. Signature of Funeral Service Licensee <b>Kimberly G. Zawotny</b>		22. Name and Address of Facility <b>PARKVILLE, MD 21234</b> <b>EVANS FUNERAL CHAPEL, 8800 HARFORD RD.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Dilated cardiomyopathy</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <b>Tasha Z Greenberg MD</b>		29c. License number <b>O C M E</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 24, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Tasha Z Greenberg M.D</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner's certificate must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Dr. Robert Wayne Garrett, DDS

2. Date of Death

Jan. 22 2004

3. Time of Death  
2:45 PM

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

453-58-0085

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 21 1937

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1807 Pot Spring Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dentist

16b. Kind of Business/Industry

Dentistry

17. Father's Name (First, Middle, Last)

Jack Vernon Garrett

18. Mother's Name (First, Middle, Maiden Surname)

Helen Louise Kennon

19a. Informant's Name/Relationship (Type, Print)

Mrs. Joyce J. Garrett/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1807 Pot Spring Rd., Lutherville, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mays Chapel Cemetery 1/26/04

Date

20c. Location - City or Town, State

Timonium, MD 21093

21. Signature of Funeral Service Licensee

Lower M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.  
10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. lung cancer

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Todd Baldanza MD

29c. License number

050592

29d. Date signed (Month, Day, Year)

January 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Todd Baldanza, M.D.

10753 Falls Rd., Suite 225, Lutherville, MD 21093

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01863

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Eugenio Gestido</b>				2. Date of Death Month Day Year <b>JANUARY 22, 2004</b>		3. Time of Death <b>5:33 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>214-44-1064</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 16, 1920</b>	
9. Birthplace (State or Foreign Country) <b>Spain</b>							
Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Lineboro</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>4601 Rills Rd.</b>				10f. Zip Code <b>21088</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Hispanic</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Diesel Engineer</b>		16b. Kind of Business/Industry <b>Engineering</b>	
17. Father's Name (First, Middle, Last) <b>Antonio Gestido</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Peregrina Ribo</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Maria Gestido/ Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4601 Rills Rd. Lineboro, Md. 21088</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem.</b>		Date <b>1-24-04</b>		20c. Location - City or Town, State <b>Timonium, Md.</b>	
21. Signature of Funeral Service licensee 				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>PERITONITIS</b> Due to (or as a consequence of): b. <b>PERFORATION OF CECUM</b> Due to (or as a consequence of): c. <b>CARCINOMA OF THE COLON</b> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D 30263</b>		29d. Date signed (Month, Day, Year) <b>01-23-04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANCIS KHOO M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204</b>							
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>				32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01266

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>William C. Gerwig</b>		2. Date of Death Month <b>January</b> Day <b>21</b> Year <b>2004</b>		3. Time of Death <b>03:05 M</b>	
4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>219-18-6680</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Aug. 22, 1925</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>4 Echoway Court Apt 2B</b>		10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Western Electric</b>	
17. Father's Name (First, Middle, Last) <b>John Gerwig</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Kurtz</b>			
19a. Informant's Name/Relationship (Type, Print) <b>sister- Elizabeth Michetti / in-law</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>35 Acorn Circle Apt 202; Towson, MD 21285</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem Gardens</b>		20c. Location - City or Town, State <b>1/24/04 Timonium, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>1050 York Road Ruck Towson Funeral Home Towson, MD 21204</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Carcinoma of Lung</b>					
23b. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):					
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
27. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  29c. License number <b>D 30263</b> 29d. Date signed (Month, Day, Year) <b>01-21-04</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANCIS KHALIL, M.D., 7001 OGLETHORPE BLVD, TOWSON, MARYLAND 21204</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b> 32. Registrar's Signature					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

CELIA GOLDMAN

2. Date of Death

January 22, 2004

3. Time of Death

8:58 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

212-05-9360

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 5, 1912

9. Birthplace (State or Foreign Country)

DE

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3631 GLENGYLE AVENUE #A-6

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES &amp; DESIGN

16b. Kind of Business/Industry

FURNITURE

17. Father's Name (First, Middle, Last)

MORRIS

LEIBOWITZ

LENA

KLASE

19a. Informant's Name/Relationship (Type, Print)

MARK GOLDMAN / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3408 PHILLIPS DRIVE - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON CHIZUK AMUNO 1/25/2004

Date

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRACRANIAL BLEEDING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION; CHRONIC ATHELECTASIS  
FIBRILLATION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D19502

29d. Date signed (Month, Day, Year)

JANUARY 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERLANDO B. CENAMAN MD

NORTHWEST HOSPITAL CENTER  
RANDALLSTOWN, MARYLAND 21133

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #98106 PER FH 6821 1/27/04 JB  
 State of Maryland / Department of Health and Mental Hygiene  
 1- For State Registrar ~~Amend Item 106 per files~~ Certificate of Death

Reg. No. 2004 010666

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>SALLY RUTH HANKS</i>		2. Date of Death Month <i>Jan</i> Day <i>14</i> Year <i>2004</i>		3. Time of Death <i>2:15 PM</i>
	4a. Facility Name (If not institution, give street and number) <i>Joseph Ritzley Hospice</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>1/a</i>
Funeral Director	5. Social Security Number <i>212 32 0038</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>69</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>Sept 23, 1934</i>		9. Birthplace (State or Foreign Country) <i>MARYLAND</i>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10a. State <i>Maryland</i>	10b. County <i>Baltimore</i>			
	10e. Street and Number <i>12 Sara 12 Sara Ct.</i>		10f. Zip Code <i>21117</i>		10g. Citizen of What Country? <i>USA</i>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>14 one</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Certified Medicine Aide</i>		16b. Kind of Business/Industry <i>Nursing Home</i>
	17. Father's Name (First, Middle, Last) <i>Samuel Leroy Williams, Jr.</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Frances Norris</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>Paula Dorsey / Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12 Sara Court Owings Mills Md 21117</i>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Pleasant Rest Cemetery</i>		20c. Location - City or Town, State <i>Towson, Maryland</i>
Physician / Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>CHATHAM - NARCO Location: 5240 Rte 108, Baltimore, Md 21206</i>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>UREMIA</i>				Approximate Interval Between Onset and Death <i>10da</i>
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>end stage renal failure (off peritoneal dialysis)</i>				
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>HTN DM</i>				23d. Date of delivery Month Day Year
To Be Completed by Physician/Medical Examiner	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i>				
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier <i>Kathleen Harrison MD</i>		29c. License number <i>D0035712</i>		29d. Date signed (Month, Day, Year) <i>1/14/04</i>
	30. Name and address of person who completed cause of death item 28e (Type, Print) <i>K. Harrison MD - Joseph R. Hickey Hospice 838 N. Euteraw St. Baltimore MD</i>				
31. Date filed (Month, Day, Year) <i>JAN 26 2004</i>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01667

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Everett Michael Haus</b>				2. Date of Death Month Day Year <b>January 24 2004</b>				3. Time of Death <b>1249 p<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>3839 Monteray Road</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-22-6815</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 1, 1926</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>										
10b. County <b>N/A</b>										
10c. City, Town or Location <b>Baltimore</b>										
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
10e. Street and Number <b>3839 Monteray Road</b>										
10f. Zip Code <b>21218</b>										
10g. Citizen of What Country? <b>U.S.A.</b>										
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates <b>Korean Conflict</b>										
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>										
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> College (1-4 or 5+)										
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerical Worker</b>										
16b. Kind of Business/Industry <b>Manufacturing</b>										
17. Father's Name (First, Middle, Last) <b>Michael Haus</b>										
18. Mother's Name (First, Middle, Maiden Surname) <b>(Names Unknown)</b>										
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Anita Barrett (niece)</b>										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5517 Daywalt Ave., Baltimore, MD 21206</b>										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>										
20c. Location - City or Town, State <b>Baltimore, Maryland</b>										
21. Signature of Funeral Service Licensee 										
22. Name and Address of Facility <b>Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236</b>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): a. <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Approximate Interval Between Onset and Death										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown										
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown										
23d. Date of delivery Month Day Year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year)										
28b. Time of Injury <b>M</b>										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Zabihullah Ali</b>										
29c. License number <b>OCME</b>										
29d. Date signed (Month, Day, Year) <b>January 27 2004</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ZABHULLAH ALI 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01068

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Thomas Hood</b>				2. Date of Death Month <b>January</b> Day <b>23</b> Year <b>2004</b>		3. Time of Death <b>3:45 P M</b>	
	4a. Facility Name (If not institution, give street and number) <b>5320 Dorsey Hall Drive #402</b>				4b. City, Town, or Location of Death <b>Ellicott City</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>215 30 2450</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 30, 1933</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Ellicott City</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>5320 Dorsey Hall Drive #402</b>		10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1952-54</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Guard</b>		16b. Kind of Business/Industry <b>Security</b>				
17. Father's Name (First, Middle, Last) <b>James T. Hood Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie V. Hall</b>				
19a. Informant's Name/Relationship (Type, Print) <b>James Thomas Hood III/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Barnstable Court Owins Mills, MD 21117</b>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>1-26-2004 Catonsville, MD</b>				
21. Signature of Funeral Service Licensee <b>Dem Collins - Witzke</b>		22. Name and Address of Facility <b>Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of): <b>b. Coronary Artery disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>William Dando MD</b>		29c. License number <b>050835</b>		29d. Date signed (Month, Day, Year) <b>1/26/04</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Dando MD 405 FREDERICK RD Ste 205 Baltimore MD 21228</b>		31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01869

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Sylvia Hemphill</i>				2. Date of Death Month <i>01</i> Day <i>22</i> Year <i>04</i>		3. Time of Death <i>2:30</i> M	
	4a. Facility Name (If not institution, give street and number) <i>Joseph Ritchie</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>219-34-5729</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>63</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>01 29 40</i>		9. Birthplace (State or Foreign Country) <i>MD</i>	
	Usual Residence of Decedent							
10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>306 N. Carrollton Ave.</i>				10f. Zip Code <i>21223</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>		
15. Decedent's Education (Specify only highest grade completed) <i>12th GRADE</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housekeeper</i>		16b. Kind of Business/Industry <i>Domestic</i>		
17. Father's Name (First, Middle, Last) <i>Lewis Lee</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Sherette Hawkins</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Thyrkield Barnes (Aunt)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>306 N. Carrollton Ave., Baltimore MD 21223</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Cemetery</i>		20c. Location - City or Town, State <i>MD</i>		
21. Signature of Funeral Service Licensee <i>Thyrkield Barnes</i>				22. Name and Address of Facility <i>Thyrkield Barnes Funeral Service 5151 Balto. Natl Pike, Baltimore, MD 21229</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>carcinoid tumor with mets</i>								Approximate Interval Between Onset and Death <i>4 yrs</i>
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>carcinoid tumor with mets</i>								
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Hospice</i>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>John W. Payne MD</i>		29c. License number <i>DI3012</i>		29d. Date signed (Month, Day, Year) <i>1/22/04</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>John W. Payne, MD 4311 Underwood Rd Baltimore, MD 21218</i>								
31. Date filed (Month, Day, Year) <i>JAN 26 2004</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01870

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>LILA HEINTZ</b>		2. Date of Death Month <b>JANUARY</b> Day <b>25</b> Year <b>2004</b>		3. Time of Death <b>530 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins BAYVIEW</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
5. Social Security Number <b>212-34-6897</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>6/19/1936</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>958 Middleborough Road</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U. S. A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operator</b>		16b. Kind of Business/Industry <b>Telephone Company</b>	
17. Father's Name (First, Middle, Last) <b>Raymond Owen Smith</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Madeline Fitzpatrick</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Gregory Ernest Roth (Husband)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>958 Middleborough Road Essex, Maryland 21221</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
20d. Date <b>1/29 2004</b>					
21. Signature of Funeral Service Licensee <b>Michael C. Taffee, Sr.</b>		22. Name and Address of Facility <b>Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221</b>			
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) <b>HEMORRHAGIC SHOCK</b>					
Due to (or as a consequence of):					
<b>Aortic ANEURYSM (SYMPTOMATIC)</b>					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Approximate Interval Between Onset and Death <b>HOURS</b>					
Approximate Interval Between Onset and Death <b>YEARS</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>J.D. Vogel M.D.</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 25, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John D. Vogel Johns Hopkins BAYVIEW HOSPITAL EASTERN AVENUE, MARYLAND</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01871

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FANNIE JENIFER</b>						2. Date of Death Month Day Year <b>January 21, 2004</b>		3. Time of Death <b>1020 M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Singa Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>			
Funeral Director	5. Social Security Number <b>220-22-1886</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN 20, 1915</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number <b>3800 W. BELVEDERE AVE</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>NA</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TECHNICIAN</b>		16b. Kind of Business/Industry <b>HOSPITAL</b>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>STEWART</b>				18. Mother's Name (First, Middle, Maiden Surname)					
	19a. Informant's Name/Relationship (Type, Print) <b>HILDA MINGLETON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4104 NEWBURN AVE. BALT. MD. 21215</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO</b>		Date <b>1-23-04</b>		20c. Location - City or Town, State <b>CATONSVILLE MD.</b>			
	21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>GARY P. MARCIA FUNERAL HOME P.A. BALT. MD. 21224</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Cerebral Vascular Accident</b> Due to (or as a consequence of): b. <b>Abnormal Seizure</b> Due to (or as a consequence of): c. <b>Hypertension</b> Due to (or as a consequence of): d. <b>Coronary Artery Disease</b>									
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown									
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown									
	23d. Date of delivery Month Day Year									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Anemia of chronic disease</b> <b>Degenerative joint disease</b>									
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <b>Willie B. MVEUBA, MD</b>				29c. License number <b>DJ5425</b>		29d. Date signed (Month, Day, Year) <b>1/22/04</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Willie B. MVEUBA 413 COMMUNICABLE AV CATONSVILLE, MD 21228</b>									
	31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>				32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland, Department of Health and Mental Hygiene  
1- For Amend & Unpend Item #1, 23a, pt. 1, 27, 28a-1, per me 6028 2/25/04  
Certificate of Death Reg. No. 2004 01872

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>John C Jackson Jr.</u>		2. Date of Death Month Day Year <u>January 18, 2004</u>		3. Time of Death <u>11:52 AM</u>
	4a. Facility Name (If not institution, give street and number) <u>2703 East Chase Street</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>
Funeral Director	5. Social Security Number <u>169-52-8786</u>	6. Sex <u>1</u> M <u>2</u> F	7. Age (In yrs. last birthday) <u>38</u> Yrs.	If Under 1 Year Months Days <u>08-24-65</u>	8. Date of Birth (Month, Day, Year)
	9. Birthplace (State or Foreign Country) <u>PA</u>				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <u>MD</u>	10b. County <u>N/A</u>	10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <u>1</u> Yes <u>2</u> No
	10e. Street and Number <u>1024 Bristol Place</u>		10f. Zip Code <u>21225</u>		10g. Citizen of What Country? <u>USA</u>
	11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: <u>85-94</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>		15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>12th GRADE</u> <u>1</u> yr. <u>College (1-4 or 5+)</u>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>TRUCK DRIVER</u>		16b. Kind of Business/Industry <u>TEMP Distribution of MD. INC.</u>		
	17. Father's Name (First, Middle, Last) <u>John C Jackson Sr.</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Shirley Knight</u>		
	19a. Informant's Name/Relationship (Type, Print) <u>MRS. Shirley Jackson (mother)</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1425 Chestnut Road, Albemarle, VA 23821</u>		
	20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Mercy St. RZUA Church</u>		20c. Location - City or Town, State <u>01-24-04 WARFIELD, VA</u>
	21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Vaughn C Greene Funeral Service</u> <u>551 Balt. Natl Pike, Baltimore, MD 21229</u>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>NARCOTIC INTOXICATION</u>				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <u>1</u> Yes <u>2</u> No <u>9</u> Unknown				
	23c. If yes, outcome of pregnancy <u>1</u> Live birth <u>2</u> Fetal death <u>3</u> Ectopic pregnancy <u>4</u> Pregnant at time of death <u>5</u> Other (Specify) <u>9</u> Unknown				
	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>				
	23e. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown				
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No		24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No		
	25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No				
	26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) <u>At scene</u>				
	27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. Date of Injury (Month, Day, Year) <u>Found 1/18/04</u>		
	28b. Time of Injury <u>Found at 7:30 a</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No		
	28d. Describe how injury occurred <u>Unknown</u>				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>Found In Dwelling</u>				
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>2703 E. Chase St. Baltimore, Maryland</u>				
	29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <u>[Signature] M.D.</u>		29c. License number <u>O.C.M.E.</u>		29d. Date signed (Month, Day, Year) <u>January 19, 2004</u>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>LING LI M.D.</u> <u>111 Penn Street, Baltimore, Maryland 21201</u>					
State Registrar	31. Date filed (Month, Day, Year) <u>JAN 26 2004</u>		32. Registrar's Signature <u>[Signature]</u>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01873

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

BERT Joseph Kirkwood

2. Date of Death  
Month Day Year

1 22 2004

3. Time of Death  
1:35 PM

4a. Facility Name (If not institution, give street and number)

Baltimore VA Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-22-9729

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 14, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

309 Presway Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+3

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mechanical Contractor

16b. Kind of Business/Industry

HVAC

17. Father's Name (First, Middle, Last)

Joseph F. Kirkwood

18. Mother's Name (First, Middle, Maiden Surname)

Helen Huber

19a. Informant's Name/Relationship (Type, Print)

Mrs. Louise Kirkwood/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

309 Presway Rd. Timonium, Md. 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Co.

Date

1-26-04

20c. Location - City or Town, State

Towson, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Lung Cancer

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P15106

29d. Date signed (Month, Day, Year)

1-22-2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ION HOBAI, MD 10N GREENE ST BALTIMORE 21201

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 01071

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>TAYBA KOSAYA</b>		2. Date of Death Month <b>JANUARY</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>11:53 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL</b>		4b. City, Town, or Location of Death <b>RAIDALSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>212-45-8022</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 19, 1919</b>
9. Birthplace (State or Foreign Country) <b>UKRAINE</b>		Usual Residence of Decedent			
10a. State <b>MD</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>6946 MILBROOK PARK DRIVE #2B</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>UKRAINE</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BOOKKEEPER</b>		16b. Kind of Business/Industry <b>POST OFFICE</b>			
17. Father's Name (First, Middle, Last) <b>GERSH KOGAN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH HASUNA</b>			
19a. Informant's Name/Relationship (Type, Print) <b>VLADIMIR KOSOY / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6907 JONES VIEW DRIVE #3B - BALTIMORE, MD 21209</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH JACOB ANSHE VESHEAR</b>		20c. Location - City or Town, State <b>1/23/2004 ROSEDALE, MD</b>	
21. Signature of Funeral Service Licensee <b>Scott M. Cottle</b>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Michael Rothkin</b>		29c. License number <b>D43481</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 20, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL ROTHKIN 5401 OLD COURT ROAD RANDALSTOWN MARYLAND 21133</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>Benjamin A. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01875

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter Carl Leineweber, Jr.

2. Date of Death

Month Day Year

JANUARY 25, 2004 3:41 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

214-12-3926

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs, last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12-14-1920 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6505 Alta Ave.

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

13

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Postal Service

17. Father's Name (First, Middle, Last)

Walter C Leineweber, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Flora Pamela Steigmann

19a. Informant's Name/Relationship (Type, Print)

Carol C Offenhimer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21436 Humbolt Square, Ashburn, VA 20147

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkview Cemetery

Date

1-31-04

20c. Location - City or Town, State

Parkville, MD

21. Signature of Funeral Service Licensee

Kimberly A. Zupotay

22. Name and Address of Facility

BALTIMORE, MD 21234  
EVANS FUNERAL CHAPEL, 8800 HARFORD RD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO-RESPIRATORY ARREST

Due to (or as a consequence of):

ARRHYTHMIA

b. Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death  
HOURS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY HYPERTENSION

LACTIC ACIDOSIS

RENAL INSUFFICIENCY

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard L. Linthicum

29c. License number

D31826

29d. Date signed (Month, Day, Year)

1-25-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD L. LINTHICUM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

Steven K. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

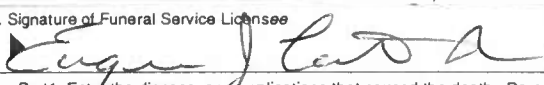
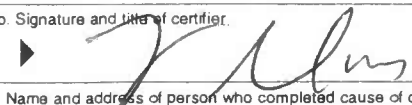

State of Maryland / Department of Health and Mental Hygiene

2004 01876

1- For  
State  
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LINDA SUE LANGFORD</b>				2. Date of Death Month Day Year <b>JAN. 24, 2004</b>				3. Time of Death <b>0345 A M</b>					
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROSEDALE</b>				4c. County of Death <b>BALTIMORE</b>					
Funeral Director	5. Social Security Number <b>213-68-9254</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>47</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>6/26/56</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>							
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	10e. Street and Number <b>606 UMBRA STREET</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STOCK PERSON</b>		16b. Kind of Business/Industry <b>WAL MART</b>							
	17. Father's Name (First, Middle, Last) <b>JAMES JEWELL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JEAN WOODWARD</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>JACK LANGFORD / HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5974 HOLLY TREE CT. FELTON, PA. 17322</b>									
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BAYVIEW CREMATORY</b>		Date <b>1/28/04</b>		20c. Location - City or Town, State <b>BALTIMORE, MD.</b>							
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>CORONARY ARTERY THROMBOSIS</b> Due to (or as a consequence of): b. <b>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown									23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29b. Signature and title of certifier. 		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JAN. 24, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIDDLE, MD 111 Penn Street, Baltimore, Maryland 21201</b>														
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>				32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01877

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Katharine Lacher</b>				2. Date of Death Month Day Year <b>January 18 2004</b>		3. Time of Death <b>9:25P M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>				4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>212-12-4829</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 14, 1916</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>824 Loyola Drive</b>		10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>		17. Father's Name (First, Middle, Last) <b>Alexander B. Gilbert</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine L. Morton</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mr. Thomas G. Lacher/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4479 Silver Peak Pkwy. Suwanee, Georgia 30024</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. Date <b>1/24/04</b>		20d. Location - City or Town, State <b>Catonsville, Maryland</b>		21. Signature of Funeral Service Licensee <b>Michael Ruck</b>	
	22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Sepsis</b> Due to (or as a consequence of): b. <b>Sterolith colitis</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death <b>Weeks</b> <b>Weeks</b>		23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fatal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	23c. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute Myocardial Infarction</b>		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
State Registrar	28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Ernestine Wright, MD</b>	
State Registrar	29c. License number <b>D52740</b>		29d. Date signed (Month, Day, Year) <b>January 19<sup>th</sup> 2004</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093</b>		31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>	
	32. Registrar's Signature <b>[Signature]</b>							



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01878

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Dorothy Barnett Larrimore</b>		2. Date of Death Month Day Year <b>January 23, 2004</b>		3. Time of Death <b>7:45 P M</b>	
4a. Facility Name (If not institution, give street and number) <b>Millennium Marley Neck</b>		4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>212-16-0886</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>JUN 1, 1920</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>205 Vernon Avenue</b>		10f. Zip Code <b>21061</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Alonza Barnett</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Cole</b>			
19a. Informant's Name/Relationship (Type, Print) <b>James R. Larrimore, Sr./Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>205 Vernon Avenue Glen Burnie, MD 21061</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <b>Edward A. Gregorchik</b>		22. Name and Address of Facility <b>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>Diffuse Atherosclerotic cerebrovascular disease</b> Due to (or as a consequence of): b. <b>Diffuse Atherosclerotic cardiovascular disease</b> Due to (or as a consequence of): c. <b>Hypertension</b> Due to (or as a consequence of): d. <b>Dementia</b>		Approximate Interval Between Onset and Death	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcohol Abuse</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Shobha Reddy M.D.</b>		29c. License number <b>D30568</b>	
29d. Date signed (Month, Day, Year) <b>January 24, 2004</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Shobha Reddy, M.D. 7845 Oakwood Road, Ste. 204, Glen Burnie, MD 21061</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01879

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>LAWRENCE CALVIN LAWSON</b>		2. Date of Death Month <b>January</b> Day <b>18</b> Year <b>2004</b>		3. Time of Death <b>4:05 am</b>
4a. Facility Name (If not institution, give street and number) <b>Maryland General Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>219 32 7319</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 7, 1937</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent		10a. State <b>Maryland</b>		
10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>301 McHECHEN STREET</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>24 YEARS</b> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Officer</b>		16b. Kind of Business/Industry <b>Private Industry</b>		
17. Father's Name (First, Middle, Last) <b>HARVEY L. LAWSON, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>AILESTER CUNNE</b>		
19a. Informant's Name/Relationship (Type, Print) <b>AILESTER LAWSON / MOTHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>504 N. CHARLES ST #411 Baltimore, Maryland 21201</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT ZION Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>
21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>CHAPMAN-NORTH FURNERAL HOME 5240 BELTS ROAD BALTIMORE, MD 21215</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Nasopharyngeal Tumor</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>89506</b>		29d. Date signed (Month, Day, Year) <b>1-18-04</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHAHID WAZIR MD c/o Maryland General Hospital</b>				
31. Date filed (Month, Day, Year) <b>JAN 26 2004</b>		32. Registrar's Signature <b>[Signature]</b>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01880

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Jacquelyn Mae MORNENTI</u>		2. Date of Death Month <u>JAN.</u> Day <u>19</u> Year <u>2004</u>		3. Time of Death <u>2:00P</u> M
	4a. Facility Name (If not institution, give street and number) <u>4930 BRISTLE CONE CIRCLE</u>		4b. City, Town, or Location of Death <u>Aberdeen</u>		4c. County of Death <u>HARFORD</u>
Funeral Director	5. Social Security Number <u>214-36-1845</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>64</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>7-4-39</u>	
	9. Birthplace (State or Foreign Country) <u>MARYLAND</u>		Usual Residence of Decedent		
To Be Completed by Funeral Director	10a. State <u>MD</u>	10b. County <u>HARFORD</u>	10c. City, Town or Location <u>Aberdeen</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <u>4930 Bristle Cone Circle</u>		10f. Zip Code <u>21001</u>		10g. Citizen of What Country? <u>USA</u>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (14 or 5+) <u>4</u>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Real Estate Settlement Office</u>		16b. Kind of Business/Industry <u>Law Firm</u>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>Albert Lauer Sr.</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Mae Stuelker</u>		
	19a. Informant's Name/Relationship (Type, Print) <u>Lara Perrault</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>75 N. Nicholas Alexander Dr., P.O. Box 104, Bel Air, MD 21034</u>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Bel Air Mem. Gardens</u>		20c. Location - City or Town, State <u>Bel Air, MD</u>
	21. Signature of Funeral Service Licensee <u>Kimberly J. Zwick</u>		22. Name and Address of Facility <u>TRANSFUNERAL PHARMACY-BEL AIR 21050</u>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>METASTATIC ADENOCARCINOMA OF PANCREAS</u>		Approximate Interval Between Onset and Death <u>MONTHS</u>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause of injury) that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSION</u>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>MAASHYANIKAR MD</u>		29c. License number <u>D25027</u>	
29d. Date signed (Month, Day, Year) <u>JANUARY 22, 2004</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>WJAY M. ARKHYANIKAR 2 NORTH AVE BEL AIR MD 21014</u>			
31. Date filed (Month, Day, Year) <u>JAN 27 2004</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01881

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GORDON LANE MILLER</b>			2. Date of Death Month Day Year <b>JANUARY 19, 2004</b>		3. Time of Death <b>1:45P. M</b>		
	4a. Facility Name (If not institution, give street and number) <b>1700 OLD EASTERN AVE</b>			4b. City, Town, or Location of Death <b>ESSEX</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>217-50-1561</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>52</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JANUARY 26, 1951</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>ESSEX</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1700 OLDEASTERN AVENUE, APT 3</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>ROSEDALE CARNIVAL</b>				
17. Father's Name (First, Middle, Last) <b>WILLIAM JAMES MILLER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>BEVERLY JEAN NYCUM</b>						
19a. Informant's Name/Relationship (Type, Print) <b>GERALD WILLIAM MILLER BROTHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>804 JOPPA FARM ROAD, JOPPA MD 21085</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EVANS FUNERAL CHAPEL BEL AIR</b>		20c. Location - City or Town, State <b>JAN. 21, 2004 FOREST HILL MARYLAND</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>PEACEFUL ALTERNATIVES 2325 YORK ROAD, TIMONIUM, MD 21093</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Intracerebral Hemorrhage</b>		23b. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 20, 2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Allen White, MD</b>		31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature 		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>		

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01282

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>MARY MARTIN</b>		2. Date of Death Month <b>JANUARY</b> Day <b>22</b> Year <b>2004</b>		3. Time of Death <b>6:25 P M</b>	
4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>386-12-6709</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F <b>XX</b>	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 21, 25</b>
9. Birthplace (State or Foreign Country) <b>Ontario Can.</b>					
Usual Residence of Decedent					
10a. State <b>Md.</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Reisterstown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>220 Park Holme Circle</b>		10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) <b>12 Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Burton LaRoy</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Gladys Evans</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Garland H Martin - Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Wyndfield Dr. Hanover, PA 17331</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Mem.</b>		20c. Location - City or Town, State <b>1/31/04 Finksburg, Md.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>11824 Reisterstown Rd. Reisterstown Md. 21136</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>RESPIRATORY FAILURE</b>					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>PNEUMONIA</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEPSIS</b>					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>PHYSICIAN</b>		29c. License number <b>D42723</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 22ND 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NORTHWEST HOSPITAL CENTER AVVERA HALLI HARISH 5401 OLD COURT ROAD MD 21133</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01883

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Francis Munchel

2. Date of Death  
Month Day Year

January 22, 2004

3. Time of Death

7:38 a.m.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220 22 1298

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 28, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1207 Shore Road

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Fireman

16b. Kind of Business/Industry

Baltimore County Fire Department

17. Father's Name (First, Middle, Last)

Leo Munchel

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Weinman

19a. Informant's Name/Relationship (Type, Print)

Juanita Munchel (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1207 Shore Road Baltimore, Maryland 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 01/26/2004 Baltimore County, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Bruzdzinski Funeral Home PA  
1407 Old Eastern Avenue Essex Maryland 21221

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Severe Ischemic Cardiomyopathy

Due to (or as a consequence of):

20 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D0057721

29d. Date signed (Month, Day, Year)

1/22/04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Laura Steele, 9000 Franklin Square Drive, Baltimore, MD. 21237

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020  
Munchel, William  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ernest Otto Malin

2. Date of Death

January 25, 2004

3. Time of Death

12:25 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

215-10-4349

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

8. Date of Birth (Month, Day, Year)

DEC 20, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8401 Avondale Road

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Copper Refining

17. Father's Name (First, Middle, Last)

Ernest Otto Malin

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Bach

19a. Informant's Name/Relationship (Type, Print)

Liz Malin/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18734 White Sand Drive Germantown, MD 20874

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

1-26-04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.  
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PROSTATE CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

1/26/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

State  
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ERNEST MALIN

JANUARY 25, 2004 12:25 p.m.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend Items#20a,b,c per FHC828 2/3/2004, PW  
Registrar  
Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Benjamin Vergara Mamaril, Sr.</b>				2. Date of Death Month <b>JANUARY</b> Day <b>11</b> Year <b>2004</b>		3. Time of Death <b>5:50A</b> M	
4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>215-27-2866</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 5, 1926</b>	
9. Birthplace (State or Foreign Country) <b>Philippines</b>		Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Lutherville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1519 York Road</b>				10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Filipino</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>Clerk</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Convenience Store</b>	
17. Father's Name (First, Middle, Last) <b>Candido Mamaril</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Luisa Vergara</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Lilia Ku Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8340 Tally Ho Road Lutherville, Maryland 21093</b>			
20a. Method of Disposition - <b>Unk</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Vall MEM Gardens</b>		20c. Location - City or Town, State <b>1/31/04 Timonium, Md</b>		20d. Date of Disposition	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>CONGESTIVE OBSTRUCTION PULMONARY DISEASE, S</b> Due to (or as a consequence of): b. <b>RECURRENT PNEUMOTHORAX</b> Due to (or as a consequence of): c. <b>ENTEROCOLITIS C/DEFICULE</b> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number <b>D 24710</b>		29d. Date signed (Month, Day, Year) <b>1-11-04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ARMANDO A. REAL, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204</b>							
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>				32. Registrar's Signature 			

State  
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01886

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES PERSON					2. Date of Death Month Day Year JANUARY 14 2004			3. Time of Death 8:30 AM	
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER					4b. City, Town, or Location of Death RANOLDSTOWN			4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 225 36 4556		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 12, 1929		9. Birthplace (State or Foreign Country) NEW YORK		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD...		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 3510 KESTON ROAD				10f. Zip Code 21207		10g. Citizen of What Country? U.S. OF A.			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH College (1-4 or 5+) UNKNOWN				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRIVER			16b. Kind of Business/Industry M.T.A. TRAINS		
	17. Father's Name (First, Middle, Last) PAUL PERSON (DECEASED)					18. Mother's Name (First, Middle, Maiden Surname) JANIE FEGURSON (DECEASED)				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) LINCOLN PERSON (BROTHER)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3510 KESTON ROAD BALTIMORE, MARYLAND 21207				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY			Date 1/20/04		20c. Location - City or Town, State CATONSVILLE, MD	
	21. Signature of Funeral Service Licensee LEWIS T. GWYNN					22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD.				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.									
	Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28e. Date of Injury (Month, Day, Year)										
28b. Time of Injury M										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier CLIFFORD FABER, MD										
29c. License number 00024970										
29d. Date signed (Month, Day, Year) JANUARY 14, 2004										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLIFFORD FABER, MD 5401 OLD COURT ROAD, RANOLDSTOWN, MARYLAND 21133										
31. Date filed (Month, Day, Year) JAN 27 2004										
32. Registrar's Signature B. Sparks										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01887

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Rose Mary Perzinski</u>				2. Date of Death Month <u>January</u> Day <u>20</u> Year <u>2004</u>		3. Time of Death <u>0535</u> M	
	4a. Facility Name (If not institution, give street and number) <u>Upper Chesapeake Center</u>				4b. City, Town, or Location of Death <u>Bel Air</u>		4c. County of Death <u>Harford</u>	
Funeral Director	5. Social Security Number <u>215-14-7694</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>80</u> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <u>April 4 1923</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <u>MD</u>	10b. County <u>Harford</u>	10c. City, Town or Location <u>Forest Hill</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <u>202 Kimary Ct. #1B</u>			10f. Zip Code <u>21050</u>		10g. Citizen of What Country? <u>USA</u>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>—</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>homemaker</u>		16b. Kind of Business/Industry <u>home</u>		
	17. Father's Name (First, Middle, Last) <u>Julius Zielinski</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Jenny Dumbrowski</u>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Joseph Perzinski - hus.</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>202 Kimary Ct. #1B Forest Hill, MD 21050</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>St. Mary's Ch. Ceme</u>		Date <u>Jan 23 2004</u>	20c. Location - City or Town, State <u>Pylesville, MD</u>		
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Evans Funeral Chapel 3 Newport Dr Forest Hill MD 21050</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Congestive heart failure</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Valvular heart disease</u> <u>Chronic obstructive pulmonary disease</u>							Approximate Interval Between Onset and Death <u>10 years</u> <u>15 years</u> <u>20 years</u>
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>[Signature] MD</u>				29c. License number <u>D0036715</u>		29d. Date signed (Month, Day, Year) <u>January 20, 2004</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>520 Upper Chesapeake Dr. Bel Air, Maryland 21014</u>								
31. Date filed (Month, Day, Year) <u>JAN 27 2004</u>				32. Registrar's Signature <u>[Signature]</u>				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01888

Physician  
(Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Earl Raymond Parrott Jr.

2. Date of Death

January 22, 2004

3. Time of Death

4:14 AM

4a. Facility Name (If not institution, give street and number)

4205 Penn Avenue

4b. City, Town, or Location of Death

Perry Hall

4c. County of Death

Baltimore

5. Social Security Number

212-36-4545

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 24, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4205 Penn Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1956-59

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Comptroller and Treasurer

16b. Kind of Business/Industry

Import Business

17. Father's Name (First, Middle, Last)

Earl Parrott

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Madeline Sprankling

19a. Informant's Name/Relationship (Type, Print)

Mary E. Iwancio / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4205 Penn Avenue Perry Hall, Maryland 21236

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory, Inc.

Date

January 24, 2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Beverly L. Heckrotte

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784  
Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Esophageal Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Paul Gormley MD

29c. License number

D18587

29d. Date signed (Month, Day, Year)

January 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL GORMLEY 900 CATON AVE

BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01889

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edward S. Peddicord</b>				2. Date of Death Month <b>January</b> Day <b>24</b> Year <b>2004</b>				3. Time of Death <b>0851 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Healthcare</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>None</b>			
Funeral Director	5. Social Security Number <b>218 12 8117</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct 17, 1923</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent											
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>715 Maiden Choice Lane CC609</b>				10f. Zip Code <b>21228</b>				10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-45</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mortgage Appraiser</b>				16b. Kind of Business/Industry <b>Banking</b>				
17. Father's Name (First, Middle, Last) <b>Robert James Brent Peddicord</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Elizabeth Carr</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Doris S. Peddicord/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>715 Maiden Choice Lane CC609 Catonsville, MD 21228</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Good Shepherd Cem.</b>				Date <b>1-29-2004</b>		20c. Location - City or Town, State <b>Ellicott City, MD</b>		
21. Signature of Funeral Service Licensee <b>Ston Collins With</b>				22. Name and Address of Facility <b>Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>acute respiratory failure</b> Due to (or as a consequence of): b. <b>Community acquired pneumonia</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>1 day</b> <b>11 days</b>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive heart failure, Coronary artery disease</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Nefeketa MD</b>				29c. License number <b>P12606</b>		29d. Date signed (Month, Day, Year) <b>January 24 2004</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nefeketa 900 S. Caton Ave Baltimore MD 21229</b>												
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>				32. Registrar's Signature <b>[Signature]</b>								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, a Medical Examiner must be notified at 505A.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Peddicord, Edward S.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01890

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Catherine Poole</i>				2. Date of Death Month: <i>January</i> Day: <i>24</i> Year: <i>2004</i> 3:35 AM				3. Time of Death	
	4a. Facility Name (If not institution, give street and number) <i>Northwest Hospital Ctr.</i>				4b. City, Town, or Location of Death <i>Randallstown, MD</i>				4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>220-20-3980</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>76</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>June 30, 1927</i>		9. Birthplace (State or Foreign Country) <i>MD</i>	
	Usual Residence of Decedent									
10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Pikesville</i>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <i>717 Cloudyfold Drive</i>				10f. Zip Code <i>21208</i>		10g. Citizen of What Country? <i>USA</i>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <i>2</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>			16b. Kind of Business/Industry <i>Own Home</i>			
17. Father's Name (First, Middle, Last) <i>Jeremiah P. McCarthy</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Agnes C. Deegah</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Gregory M. Poole Son</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>304 Central Ave. Glen Burnie, MD 21061</i>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>New Cathedral Cem.</i>		20c. Location - City or Town, State <i>Baltimore, MD</i>		20d. Date <i>1/27/04</i>		
21. Signature of Funeral Service Licensee <i>Eline Poole</i>				22. Name and Address of Facility <i>Eline Funeral Home Reisterstown, MD 21136</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>thp 12 hr</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown										
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown										
23d. Date of delivery Month Day Year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Alvin Hirsch</i>				29c. License number <i>1143974</i>			29d. Date signed (Month, Day, Year) <i>January 24, 2004</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Alvin Hirsch Northwest Hospital Randallstown, Maryland</i>										
31. Date filed (Month, Day, Year) <i>JAN 27 2004</i>				32. Registrar's Signature <i>Alvin Hirsch</i>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

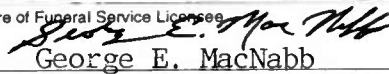
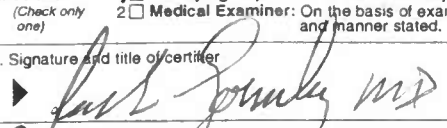

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01891

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael Stephen Powell				2. Date of Death Month Day Year JAN. 22, 2004		3. Time of Death 4:30a M	
	4a. Facility Name (If not institution, give street and number) 7 Magruder Avenue				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-56-0256	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUL 29, 1950		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 7 Magruder Avenue				10f. Zip Code 21228		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Editor/Journalist		16b. Kind of Business/Industry Newspaper	
	17. Father's Name (First, Middle, Last) Roland Alvah Powell				18. Mother's Name (First, Middle, Maiden Surname) Helen Margaret MacDonald			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Anne P. Powell/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Magruder Avenue Catonsville, MD 21228			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 1/26/04		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee  George E. MacNabb				22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Esophageal Cancer</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 1/2 yrs
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  Paul Gormley MD				29c. License number D18587		29d. Date signed (Month, Day, Year) JAN 22 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL GORMLEY 900 CATON AVE BALTIMORE MD 21229								
31. Date filed (Month, Day, Year) JAN 27 2004		32. Registrar's Signature  Paul Sparks						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01892

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Maude E. Provins			2. Date of Death Month Day Year January 19 2004		3. Time of Death 20:07 PM	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore			4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 426-01-1607	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 8, 1918	9. Birthplace (State or Foreign Country) Mississippi
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Glen Arm			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 11630 Glen Arm Road Unit 227			10f. Zip Code 21057		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Leroy Fuller			18. Mother's Name (First, Middle, Maiden Surname) Lena Kratzschmar			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Paula E. Lewin / daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Teaneck Court; Timonium, MD 21093			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Men Gardens		Date 1/23/04		20c. Location - City or Town, State Timonium, MD
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Ruck Towson Funeral Home 1050 York Road Towson, MD 21204				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. intracerebral hemorrhage Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 days						
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. non-insulin-dependent diabetes hypertension						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature] M. Darland, MD					
29c. License number RES-000		29d. Date signed (Month, Day, Year) January 19, 2004					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mariya F. Darland, MD Sinai Hospital of Baltimore							
31. Date filed (Month, Day, Year) JAN 27 2004		32. Registrar's Signature [Signature]					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician / Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified in advance.

Baltimore, Maryland 21215-0036

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- Amend Item #8 per fh G828 2/18/04  
Certificate of Death

Reg. No.

2004 01893

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Astrea A. Rector				2. Date of Death Month Day Year 01 21 04		3. Time of Death 6:00 A.M.		
	4a. Facility Name (If not institution, give street and number) Sunrise Assistant Living Facility				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 578-20-6985	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9/17/1914 <del>01 21 04</del>		Birthplace (State or Foreign Country) Chantilly, VA.	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State D.C.		10b. County Washington		10c. City, Town or Location Washington		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 1424 Webster Street N.W.				10f. Zip Code 20011		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th. College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry U.S. Government		
	17. Father's Name (First, Middle, Last) Henry Allen				18. Mother's Name (First, Middle, Maiden Surname) Geneva Douglas				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Carl Kaiser Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2507 Dennis Avenue Silver Spring, Md. 20902				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cem.		Date 1-26-04		20c. Location - City or Town, State Suitland, MD.		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer								
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown				3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number 00057304		29d. Date signed (Month, Day, Year) 1/22/04			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Eirne Koroulakis, MD.									
31. Date filed (Month, Day, Year) JAN 27 2004		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01894

Physician / Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Helen Virginia Roberts</b>				2. Date of Death Month <b>Jan.</b> Day <b>23</b> Year <b>2004</b>		3. Time of Death <b>6:01 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>				4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>217-05-4749</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nvo. 25 1915</b>	
9. Birthplace (State or Foreign Country) <b>MD</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>724 B-1 Camberley Circle</b>				10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>n/a</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Railroad</b>	
17. Father's Name (First, Middle, Last) <b>Harry Johnson</b>				18. Mother's Name (First, Middle, Maiden Sumame) <b>Helen Virginia Armstrong</b>			
19a. Informant's Name/Relationship (Type, Print) <b>B. Donald Scheck/nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13948 Jarrettsville Pike, Phoenix, MD 21131</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cem.</b>		Date <b>1/27/04</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <b>Michael J. Nagle</b>				22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093</b>			

To Be Completed by Funeral Director

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiomyopathy</b>				Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. Due to (or as a consequence of): <b>Myocardial Infarction</b>	
				b. Due to (or as a consequence of):	
				c. Due to (or as a consequence of):	
				d. Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cognitive heart failure Myocardial infarction</b>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>015504</b>		29d. Date signed (Month, Day, Year) <b>1-23-04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>EDDIE NAKHODA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093</b>					

To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>	32. Registrar's Signature <b>[Signature]</b>
---	---

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

JANUARY 23, 2004 - 6:01 A.M.

ROBERTS, HELEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01895

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clayton James Reynolds

2. Date of Death

January 24, 2004

3. Time of Death

1:20 am M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Heritage Nursing Home

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

5. Social Security Number

215-12-1257

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
8/3/1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

810 Briarhill Place

10f. Zip Code

21221

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates:

1943

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Steven Reynolds

18. Mother's Name (First, Middle, Maiden Surname)

Ella Hofmeister

19a. Informant's Name/Relationship (Type, Print)

(Brother)  
George Irving Thompson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

824 Woodrow Avenue Essex, Maryland 21221

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gard.

Date

1/27

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael C. Jaffan Sr.

22. Name and Address of Facility

Bruzdinski Funeral Home PA  
1407 Old Eastern Avenue Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

b. DIABETES MELLITUS

Due to (or as a consequence of):

c. MALNUTRITION

Due to (or as a consequence of):

d. DEHYDRATION

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

28. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Savinder K. Tucka MD

29c. License number

D27188

29d. Date signed (Month, Day, Year)

1/25/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Savinder K. Tucka 2 Market Place Dundalk MD 21222

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

B. A. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01896

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH ROSENBAUM</b>		2. Date of Death Month <b>January</b> Day <b>22</b> Year <b>2004</b>		3. Time of Death <b>1242 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital of Baltimore</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>220-07-3902</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>DEC. 28, 1918</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>
	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>712 LEAFYDALE TERRACE</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>HOMEMAKER</b>		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>OWN HOME</b>		
	17. Father's Name (First, Middle, Last) <b>JACOB BUTLER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>FANNY (UNKNOWN)</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>MICHAEL ROSENBAUM / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1506 ELM STREET - EL CERRITO, CA 94530</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW CEM.</b>		20c. Location - City or Town, State <b>REISTERSTOWN, MD</b>
	21. Signature of Funeral Service Licensee <i>Michael Singer</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Congestive Heart Failure</b> Due to (or as a consequence of): b. <b>Aortic Stenosis.</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify): <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Kevin Hayes D.O.</i>					
29c. License number <b>RES-000</b>					
29d. Date signed (Month, Day, Year) <b>JANUARY 22, 2004</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kevin Hayes D.O. Sinai Hospital of Baltimore</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>					
32. Registrar's Signature <i>James B. Sparks</i>					

Ruth Rosenbaum  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01897

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>TONY SWINSON</b>				2. Date of Death Month <b>01</b> Day <b>05</b> Year <b>04</b> <b>6:59P M</b>		3. Time of Death <b>6:59P M</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>240 30 1009A</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR. 2, 2003</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> Yes <b>2</b> No				10e. Street and Number <b>4630 PIMLICO ROAD</b>		10f. Zip Code <b>21215</b>	
	10g. Citizen of What Country? <b>U.S. OF A.</b>				11. Marital Status <b>1</b> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No <b>1944-</b> <b>1</b> Yes, Give Year or Dates: <b>1946</b>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4or 5+) <b>UNKNOWN</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>				16b. Kind of Business/Industry <b>MARYLAND DRY DOCK</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>PATTIE EDWARD (DECEASED)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>GENE E. SWINSON (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4630 PIMLICO ROAD BALTIMORE, MARYLAND 21215</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <b>1</b> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>CROWNSVILLE VET. CEM. 1/13/04 CROWNSVILLE, MARYLAND</b>		20c. Location - City or Town, State	
	21. Signature of Funeral Service Provider <b>Lewis T. Gwynn</b>				22. Name and Address of Facility <b>LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD.</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>ARRYTHMIA</b> Due to (or as a consequence of): b. <b>ENCEPHALOPATHY</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Was decedent pregnant in the past 12 months? <b>1</b> Yes <b>2</b> No <b>9</b> Unknown		23c. If yes, outcome of pregnancy <b>1</b> Live birth <b>2</b> Fetal death <b>4</b> Pregnant at time of death <b>9</b> Unknown	
	23d. Date of delivery Month Day Year				23e. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> Probably <b>4</b> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <b>1</b> Yes <b>2</b> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Peter mo</b>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>P15807</b>				29d. Date signed (Month, Day, Year) <b>1/5/04</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>22 S GREENE ST BALTIMORE, MD 21201</b>				31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>Boys B Sparks</b>				33. State Registrar's Signature			
	34. State Registrar's Signature				35. State Registrar's Signature			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 19a, per Inf. 6829, 3/5/04 CC

State of Maryland / Department of Health and Mental Hygiene

2004 01898

1- For State Registrar Amend Item #1 per PHY, #5 per FHG828

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Rehana Syed</u> Rehana Syed			2. Date of Death Month <u>January</u> Day <u>25</u> Year <u>2004</u>		3. Time of Death <u>10:41 AM</u>				
	4a. Facility Name (If not institution, give street and number) <u>Sinai Hospital of Baltimore</u>			4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death				
Funeral Director	5. Social Security Number <u>043-54-4348</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>60</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>June 6 1943</u>		9. Birthplace (State or Foreign Country) <u>India</u>			
	Usual Residence of Decedent									
10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Pikesville</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <u>7509 Rock Ridge Rd</u>			10f. Zip Code <u>21208</u>		10g. Citizen of What Country? <u>USA</u>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Indian</u>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>5+</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>office clerk</u>			16b. Kind of Business/Industry <u>Northwest Hospital</u>				
17. Father's Name (First, Middle, Last) <u>Syed Hussain Ahmed</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Bakia Zaidi</u>						
19a. Informant's Name/Relationship (Type, Print) <u>Shahid A. Syed</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7509 Rock Ridge Rd Pikesville, MD 21208</u>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Rose Hill Cemetery</u>		20c. Location - City or Town, State <u>Lincoln, New Jersey</u>		20d. Date <u>Jan 27 2004</u>				
21. Signature of Funeral Service Licensee <u>Heather Wells</u>		22. Name and Address of Facility <u>Evans Funeral Chapel</u> <u>8800 Harford Rd Baltimore MD 21234</u>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Sepsis</u> Due to (or as a consequence of): <u>Acute Respiratory Distress Syndrome</u> <u>Acute Renal Failure</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary Artery Disease</u> <u>Ischemic Hepatitis</u> <u>Gastrointestinal Bleed</u>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred								
28f. Location (Street and Number or Rural Route Number, City or Town, State)		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier <u>Neva Ouilikan MD</u>		29c. License number <u>RES-000</u>	
29d. Date signed (Month, Day, Year) <u>January 25, 2004</u>							29e. Date of Death			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Neva Ouilikan MD Sinai Hospital of Baltimore</u>							31. Date filed (Month, Day, Year) <u>JAN 27 2004</u>			
31. Registrar's Signature <u>[Signature]</u>							31. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01899

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) Louise Springborn						2. Date of Death Month Day Year January 24, 2004			3. Time of Death 7:15 pm		
4a. Facility Name (If not institution, give street and number) Friends Nursing Home						4b. City, Town, or Location of Death Sandy Spring			4c. County of Death Montgomery		
5. Social Security Number 102-05-8410			6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 22, 1917		9. Birthplace (State or Foreign Country) New York		
Usual Residence of Decedent											
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Sandy Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 17340 Quaker Lane				10f. Zip Code 20832				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Charles Seiler						18. Mother's Name (First, Middle, Maiden Surname) Katherine Hug					
19a. Informant's Name/Relationship (Type, Print) Lucille Ridlon/daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7156 Mink Hollow Road Highland, Maryland 20777					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory		Date January 27, 2004		20c. Location - City or Town, State Odenton, Maryland			
21. Signature of Funeral Service Licensee Beverly L. Heckrotte MO1251				22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029							

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Acute Coronary Insufficiency Due to (or as a consequence of):		30 minutes	
		b. Congestive Heart Failure Due to (or as a consequence of):		3 weeks	
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier Bennett Morrison M.D.						29c. License number D47682			29d. Date signed (Month, Day, Year) January 26, 2004		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Bennett Morrison M.D. 2901 Olney-Sandy Spring Road Olney, Maryland 20832											

State  
Registrar

31. Date filed (Month, Day, Year) JAN 27 2004		32. Registrar's Signature	
--	--	---------------------------	--

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01900

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>William King Smith</b>		2. Date of Death Month Day Year <b>January 25, 2004</b>		3. Time of Death <b>1:50 pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Morningside House</b>			4b. City, Town, or Location of Death <b>Ellicott City</b>		4c. County of Death <b>Howard</b>
5. Social Security Number <b>168-03-4068</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 27, 1915</b>
9. Birthplace (State or Foreign Country) <b>Kentucky</b>					
Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Howard</b>	
10c. City, Town or Location <b>Ellicott City</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>5330 Dorsey Hall Drive</b>		10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>2</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer System Developer</b>	
17. Father's Name (First, Middle, Last) <b>Arthur H. Smith</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Irene Garrity</b>		16b. Kind of Business/Industry <b>Computer Technology</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Gary R. Smith/son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11821 Chapel Woods Court Clarksville, MD 21029</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>West Arundel Crematory</b>		20c. Location - City or Town, State <b>26, 2004 Odenton, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Beverly L. Heckrotte</b>		22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>BLADDER CANCER</b> Due to (or as a consequence of):  b. <b>RENAL FAILURE</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>Months</b> <b>Months</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D22856</b>	
		29d. Date signed (Month, Day, Year) <b>January 26, 2004</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jane L. Levine, MD 11955 L. McPherson Pk, Columbia, MD 21046</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01901

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hina Shah</b>				2. Date of Death Month <b>January</b> Day <b>23</b> Year <b>2004</b>		3. Time of Death <b>2:15A</b>	
	4e. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>149-72-6321</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>34</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 3, 1969</b>	
	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Odenton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2757 Summers Ridge Drive</b>		10f. Zip Code <b>21113</b>		10g. Citizen of What Country? <b>United States</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Asian Indian</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Microbiologist</b>		16b. Kind of Business/Industry <b>Medical</b>				
17. Father's Name (First, Middle, Last) <b>Subodhchandra Jayantilal Shah</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nirmala Purshottam Shah</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Jayesh Shah/ Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2757 Summers Ridge Drive Odenton, Maryland 21113</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>West Arundel Crematory</b>		Date <b>1/25/04</b>		20c. Location - City or Town, State <b>Odenton, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Quantia R Thomas</b> M00957		22. Name and Address of Facility <b>Donaldson Funeral Home &amp; Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature] MD</b>		29c. License number <b>D48006</b>		29d. Date signed (Month, Day, Year) <b>January 23, 2004</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>KOFI BURNITTEN, 301 Hospital Dr., Glen Burnie, MD</b>								
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lettie Virginia Sheeler

2. Date of Death

January 21, 2004

3. Time of Death

2:00 p M

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

219-16-6548

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 3 1916

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Sparks

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1J Shelby's Path

10f. Zip Code

21152

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

manager

16b. Kind of Business/Industry

Valley View Farms

17. Father's Name (First, Middle, Last)

Robert Chaffman

18. Mother's Name (First, Middle, Maiden Surname)

Annie Turnbaugh

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Sheeler/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 J Shelby's Path, Sparks, MD 21152

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Jessops Church Cem. 1/24/04

Date

20c. Location - City or Town, State

Sparks, MD

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or Injury

that initiated events

resulting in death) Last

Approximate

Interval Between

Onset and Death

10 years

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rodney Williams MD

29c. License number

D39099

29d. Date signed (Month, Day, Year)

1-23-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RODNEY W. WILLIAMS MD 6701 N CHARLES ST. BALTO MD 21204

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

Kathleen E. Sparks

State  
RegistrarBaltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01903

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Addie Starks</i>		2. Date of Death Month <i>01</i> Day <i>24</i> Year <i>2004</i>		3. Time of Death <i>4:15</i> M
	4a. Facility Name (If not institution, give street and number) <i>Catonsville Commons</i>		4b. City, Town, or Location of Death <i>Catonsville</i>		4c. County of Death <i>Baltimore</i>
Funeral Director	5. Social Security Number <i>217-22-1417</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>81</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>FEB 2, 1922</i>	9. Birthplace (State or Foreign Country) <i>Georgia</i>
	10a. State <i>Maryland</i>		10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>	
To Be Completed by Funeral Director	10e. Street and Number <i>4800 Frederick Avenue</i>		10f. Zip Code <i>21229</i>		10g. Citizen of What Country? <i>USA</i>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>
	17. Father's Name (First, Middle, Last) <i>Alex Andrews</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Ida Davis</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>Rudolph Turner/Nephew</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4800 Frederick Avenue Baltimore, MD 21229</i>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory Inc.</i>		20c. Location - City or Town, State <i>Baltimore, MD</i>
	21. Signature of Funeral Service Licensee <i>Edward A. Gogorchik</i>		22. Name and Address of Facility <i>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</i>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Dementia</i> a. Due to (or as a consequence of): <i>peripheral Vascular disease</i> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <i>Dr. Attending Physician</i>		29c. License number <i>D53642</i>		29d. Date signed (Month, Day, Year) <i>Jan. 25 2004</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>X/ROBERTA 5601 Loch Raven Blvd 303 Baltimore 21259</i>					
31. Date filed (Month, Day, Year) <i>JAN 27 2004</i>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01904

1- Amend Item #23a, Part II, 27, Per ME G828 2/03/04 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Walter Stinchcomb</b>		2. Date of Death Month Day Year <b>January 25 2004</b>		3. Time of Death <b>0216 aM</b>
	4a. Facility Name (If not institution, give street and number) <b>7601 Plummers Pasture Lane</b>		4b. City, Town, or Location of Death <b>Severn</b>		4c. County of Death <b>Anne Arundel</b>
Funeral Director	5. Social Security Number <b>215-64-4878</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>JAN 30, 1957</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		
To Be Completed by Funeral Director	10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severn</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>7601 Plummers Pasture Lane</b>		10f. Zip Code <b>21144</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Auto Mechanic</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Auto Mechanic</b>		16b. Kind of Business/Industry <b>Automotive Repair</b>		
	17. Father's Name (First, Middle, Last) <b>Victor Everett Stinchcomb, Jr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sara Anne Smith</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Sara A. Stinchcomb/Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1578 B &amp; A Boulevard Arnold, MD 21012</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>
	21. Signature of Funeral Service Licensee <b>Edward A. Gregorchik</b>		22. Name and Address of Facility <b>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Smoke Inhalation and Thermal Injuries Complicating Ethanol Intoxication</b>				
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>a. Intoxication</b> Due to (or as a consequence of): <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atherosclerotic Cardiovascular Disease</b>					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>1/24/04</b>		28b. Time of Injury <b>2205 M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>SUBJECT WTS IN A HOUSE FIRE</b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>AT HOME</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>7601 PLUMBERS PASTURE LANE SEVERN, MD</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>January 25 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY E. CABLE MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

3053

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01905

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>ELIOT SHIMOFF</b>		2. Date of Death Month Day Year <b>JAN-24-2004</b>		3. Time of Death Hour Minute AM/PM <b>1:05 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>LEVINDALE HEBREW HOME</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>054-36-8343</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>JAN. 24, 1943</b>		9. Birthplace (State or Foreign Country) <b>VA</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>5800 STUART AVENUE</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COLLEGE PROFESSOR - PSYCHOLOGY EDUCATION</b>		16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) <b>EPHRAIM SHIMOFF</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SHIRLEY MANN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>SANDRA SHIMOFF / WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5800 STUART AVENUE - BALTIMORE, MD 21215</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARETZ CHAIM CEMETERY</b>		20c. Date <b>1/25/2004</b>	
20d. Location - City or Town, State <b>BEIT SHEMESH, ISRAEL</b>					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>acute myocardial infarction</b>		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>metastatic prostate cancer</b>		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D44817</b>	
29d. Date signed (Month, Day, Year) <b>JAN-24-2004</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sherif Hegami 2434 W Belvedere Ave, Baltimore MD 21215</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01906

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph A. Sliakis</b>						2. Date of Death Month Day Year <b>January 22, 2004</b>			3. Time of Death <b>5:10 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis Cromwell Center</b>						4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>094-03-7745</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>94</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 8, 1909</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent						10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						10e. Street and Number <b>205 East Joppa Road</b>		10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>United State Postal Service</b>			16b. Kind of Business/Industry <b>Postal Service</b>					
	17. Father's Name (First, Middle, Last) <b>Adam Sliakis</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Remeikis</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Anna Monfredo / Sister</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>205 E. Joppa Road Towson, Maryland 21286</b>				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>1/26/04</b>		20c. Location - City or Town, State <b>Towson, Md.</b>				
	21. Signature of Funeral Services Licensee 						22. Name and Address of Facility <b>1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>				
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <u>and stage senile dementia</u></b> Due to (or as a consequence of):										Approximate Interval Between Onset and Death <b>years</b>
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of):										
	<b>c. _____</b> Due to (or as a consequence of):										
<b>d. _____</b> Due to (or as a consequence of):											
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier <b>MARtha Raimundo, MD</b>		29c. License number <b>D54418</b>		29d. Date signed (Month, Day, Year) <b>1/25/04</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARtha C. RAIMUNDO 5601 LOCHRAVEN BVD BALTIMORE MD 21237</b>										
	31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature 								

Lauren Patricia Snyder  
04-00496  
MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01907

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Lauren Patricia Snyder</b>		2. Date of Death Month <b>January</b> Day <b>17</b> Year <b>2004</b>		3. Time of Death <b>2050P M</b>	
4a. Facility Name (If not institution, give street and number) <b>6949 Ten Timbers Lane</b>		4b. City, Town, or Location of Death <b>Pikesville</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>213-68-4569</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>37</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Nov. 15, 1966</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Mt. Washington</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>6949 Ten Timbers Lane</b>		10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Legal Specialist</b>		16b. Kind of Business/Industry <b>Law</b>	
17. Father's Name (First, Middle, Last) <b>James P. Kosker</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Geraldine M. Dobrzykowski</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Bruce A. Snyder Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6949 Ten Timbers Lane Mt. Washington, Maryland 21209</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp. 1-21-2004</b>		20c. Location - City or Town, State <b>Towson Maryland</b>	
21. Signature of Funeral Director/Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Asphyxia due to hanging</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>At scene</b>			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>11/7/04</b>		28b. Time of Injury <b>8:20 P M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject hanged self</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>6949 Ten Timbers Lane, Pikesville, MD</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i> <b>ZABILLI ALI</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>January 18, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ZABILLI ALI 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <i>[Signature]</i>			



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #1 State of Maryland / Department of Health and Mental Hygiene  
Unpend Item #23a, Part II, 27, Per Me, C83047/04eg  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Darlen Preston</b>			2. Date of Death Month Day Year <b>January 13, 2004</b>			3. Time of Death <b>7:15 P M</b>		
	4a. Facility Name (If not institution, give street and number) <b>1020 West Saratoga Street</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>214 78 3739</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>38</b> Yrs.	8. Date of Birth Month Day Year <b>Aug. 9, 1965</b>		9. Birthplace (State or Foreign Country) <b>NEW JERSEY</b>			
	10a. State <b>Maryland</b>			10b. County <b>N/A</b>			10c. City, Town or Location <b>Baltimore</b>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>200 S. ARLINGTON AVE</b>			10f. Zip Code <b>21223</b>			
10g. Citizen of What Country? <b>USA</b>			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2 YRS</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CASHIER</b>			16b. Kind of Business/Industry <b>STORE</b>			17. Father's Name (First, Middle, Last) <b>GILBERT Sanford</b>			
18. Mother's Name (First, Middle, Maiden Surname) <b>CARRIE BAKER</b>			19a. Informant's Name/Relationship (Type, Print) <b>CARRIE CARTER MOTHER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>151 BURLINGTON MANOR BRIDGETON N.J. 08302</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREENPOINT CEMETERY</b>			20c. Location - City or Town, State <b>1-19-04 Baltimore Maryland</b>			
21. Signature of Funeral Service Licensee <b>Dany Harris</b>			22. Name and Address of Facility <b>CATHMAN - NORTH Funeral Home 5200 REISTERSTOWN ROAD BALTIMORE, MD 21121</b>			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acquired Immunodeficiency Syndrome(AIDS)</b>			
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year			
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			
28a. Date of Injury (Month, Day Year)			28b. Time of Injury <b>M</b>			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>Theodore H. Kigans</b>			29c. License number <b>O.C.M.E.</b>			
29d. Date signed (Month, Day, Year) <b>January 14, 2004</b>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE H. KIGANS 111 Penn Street, Baltimore, Maryland 21201</b>			31. Date filed (Month, Day, Year) <b>JAN 26 2004</b>			
32. Registrar's Signature <b>B. Sparks</b>									

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01909

1- For State Registrar

Physician / Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>BOBBY R. THOMAS JR.</b>		2. Date of Death Month Day Year <b>JANUARY 11 2004</b>		3. Time of Death <b>4:48 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>219 68 1546</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>47</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>JAN. 5, 1957</b>	9. Birthplace (State or Foreign Country) <b>South Carolina</b>	
Usual Residence of Decedent		10a. State <b>MD.</b>		10b. County <b>N/A</b>	
10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>330 S. FRANKLINTOWN ROAD</b>		10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S. OF A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>3 YEARS</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRODUCE SALESMAN</b>		16b. Kind of Business/Industry <b>SUPER MARKET</b>	
17. Father's Name (First, Middle, Last) <b>BOBBY RUSSELL THOMAS, SR. (DECEASED)</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA HOOKER (DECEASED)</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MARY R. FORD (SISTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>330 S. FRANKLINTOWN RD. BALTO., MD. 21223</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		20c. Location - City or Town, State <b>1/17/04 LANSLOWNE, MARYLAND</b>	
21. Signature of Funeral Service Licensee <b>Lewis T. Gwynn</b>		22. Name and Address of Facility <b>LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Septic Shock</b> Due to (or as a consequence of): <b>upper GI tract bleeding</b> Due to (or as a consequence of): <b>Heroin abuse</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute Renal Failure</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Chp. Celms</b>		29c. License number <b>D18327</b>	
29d. Date signed (Month, Day, Year) <b>1/11/04</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Moges Gebremariam 4660 Wilkens Ave Balto Md 21229</b>			
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature <b>James B. Sparks</b>			

Baltimore, Maryland 21215-0036

Physician / Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01910

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leroy A. Wooden</b>				2. Date of Death Month <b>Jan</b> Day <b>21</b> Year <b>2004</b>		3. Time of Death <b>6:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>833 W. Pratt St. Apt 413</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-01-5994</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 11 1919</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>833 W. Pratt St. Apt 413</b>		10f. Zip Code <b>21201</b>	
	10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steel Worker</b>	
	16b. Kind of Business/Industry <b>Steel</b>				17. Father's Name (First, Middle, Last) <b>John Wooden</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Edna</b>	
Physician / Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Jerlene Boyd / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19 S. Calverton Rd. Balt MD 21223</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		20c. Date <b>1-28-04</b>		20d. Location - City or Town, State <b>Quings Mill, MD 21229</b>	
Physician / Medical Examiner	21. Signature of Funeral Service Licensee <b>Gary P March</b>				22. Name and Address of Facility <b>Gary P March F/H 270 Fredhillon Pass Balt MD</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pancreatic Cancer</b>				Approximate Interval Between Onset and Death <b>2 months</b>			
To Be Completed by Physician/Medical Examiner	23b. If FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			
	23d. Date of delivery Month Day Year				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)			
	28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>Eric Goldberg, M.D.</b>				29c. License number <b>DOOSTP18</b>			
	29d. Date signed (Month, Day, Year) <b>1/23/04</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Eric Goldberg 22 South Greene Street NW62 Baltimore, MD 21201</b>			
State Registrar	31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>				32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

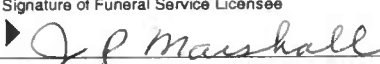
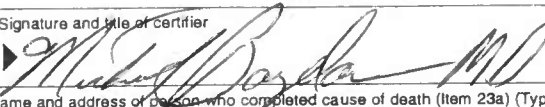

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>SENORA WHITFIELD</b>		2. Date of Death Month <b>JAN</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>8:36 P M</b>	
4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>226-42-2976</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>02 26 17</b>	9. Birthplace (State or Foreign Country) <b>Richmond, VA.</b>	
Usual Residence of Decedent					
10a. State <b>D.C.</b>		10b. County		10c. City, Town or Location <b>Washington</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>1814 T Street N.W.</b>		10f. Zip Code <b>20009</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business/Industry <b>Hospital</b>	
17. Father's Name (First, Middle, Last) <b>Charles L. Johnson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Charity L. Pollard</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Chantal Whitfield Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1814 T Street N.W. Washington, D.C. 20009</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National</b>		20c. Location - City or Town, State <b>Arlington, VA.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>01055104A (IN)</b>		29d. Date signed (Month, Day, Year) <b>JAN 21, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL R. BAYDARIAN LT MC USNR NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01912

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William George Wantland

2. Date of Death

January 22, 2004

3. Time of Death

9:04 P M

4a. Facility Name (If not institution, give street and number)

1905 Swift Fox Court

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

219-34-4636

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 24, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1905 Swift Fox Ct.

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Bar/Restaurant

17. Father's Name (First, Middle, Last)

William George Wantland

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Viola Hill

19a. Informant's Name/Relationship (Type, Print)

Mrs. Jessica J. Wantland (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1905 Swift Fox Ct., Fallston, Maryland 21047

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bayview Crematory

Date

1/26/2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes

9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Small Cell Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

15 months

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Julie R. Brahmer, MD

29c. License number

D0051770

29d. Date signed (Month, Day, Year)

January 23 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julie R. Brahmer, MD 1650 Orleans Street Baltimore Maryland 21231

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified in  
writing.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia Lee Wiser</b>				2. Date of Death Month <b>January</b> Day <b>22</b> Year <b>2004</b>				3. Time of Death <b>11:10 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>219-40-3614</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 4, 1943</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>			
	Usual Residence of Decedent				10a. State <b>MD</b>				10b. County <b>BALTIMORE</b>			
To Be Completed by Funeral Director	10c. City, Town or Location <b>Dundalk</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>86 YORKWAY APT D</b>			
	10f. Zip Code <b>21222</b>				10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>				16b. Kind of Business/Industry <b>own home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>FRANK Debilous</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eleanor KHALER</b>				19a. Informant's Name/Relationship (Type, Print) <b>Kimberly Purta /daughter</b>			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2106 JASMINE Rd. Dundalk, Md 21222</b>				20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BAYVIEW CEMETERY</b>			
To Be Completed by Physician/Medical Examiner	20c. Location - City or Town, State <b>BALTO. MD</b>				21. Signature of Funeral Service Licensee <b>Anthony C. Connelly</b>				22. Name and Address of Facility <b>Funeral Home of Dundalk 7110 Sollew Pt. Rd. Dundalk, Md 21222</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Pulmonary Embolism</b> Due to (or as a consequence of): b. <b>Pneumonia</b> Due to (or as a consequence of): c. <b>Small Cell Lung Cancer</b> Due to (or as a consequence of): d. <b></b>				Approximate Interval Between Onset and Death <b>5 hours</b> <b>2 days</b> <b>2 months</b>				23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month <b></b> Day <b></b> Year <b></b>				23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				23h. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	27. Date of Injury (Month, Day, Year) <b></b>				27b. Time of Injury <b>M</b>				27c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	27d. Describe how injury occurred <b></b>				27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b></b>				27f. Location (Street and Number or Rural Route Number, City or Town, State) <b></b>			
	28a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				28b. Signature and title of certifier <b>CM</b>				28c. License number <b>RES-000</b>			
To Be Completed by Physician/Medical Examiner	28d. Date signed (Month, Day, Year) <b>January 22, 2004</b>				28e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Josefina R. Vera 4940 Eastern Ave Baltimore MD 21224</b>				28f. Date filed (Month, Day, Year) <b>JAN 27 2004</b>			
	28g. Registrar's Signature <b></b>				28h. Date signed (Month, Day, Year) <b></b>				28i. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b></b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2004 019116

1- For  
State  
Registrar

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

STANLEY

2. Date of Death

January 15 2004

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

MD

5. Social Security Number

243 11 7907

6. Sex

M

7. Age (in yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 18, 1955

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

MD

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

5205 DENMORE AVE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)  
12th grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CROONER

16b. Kind of Business/Industry

RACE TRACK

17. Father's Name (First, Middle, Last)

JOHN WILLARD WIGGINS

18. Mother's Name (First, Middle, Maiden Surname)

Vernell West

19a. Informant's Name/Relationship (Type, Print)

Crystal Weaver / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5205 DENMORE AVE Baltimore MD 21215

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Carmel Cemetery

Date

1/21/04

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHA THAN - HANIS Funeral Home

5240 REISTERSTOWN ROAD  
Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CIRRHOSIS

Due to (or as a consequence of):

b. HEPATITIS C

Due to (or as a consequence of):

c. ALCOHOL ABUSE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death  
years

years

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 Yes 2 No  
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death  
4 Pregnant at time of death  
9 Unknown

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?  
1 Yes 2 No24b. Were autopsy findings available prior to completion of cause of death?  
1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature of certifier

29c. License number

29d. Date signed (Month, Day, Year)

29e. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29f. Date filed (Month, Day, Year)

29g. Registrar's Signature

29h. State Registrar

29i. Date of Death

29j. Registrar's Signature

29k. Date of Death

29l. Registrar's Signature

29m. Date of Death

29n. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2004 01915

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Evelyn Winemiller

2. Date of Death

Month Day Year  
January 24, 2004

3. Time of Death

12:15 PM

4a. Facility Name (If not institution, give street and number)

The Wesley

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

218-34-0341

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 24, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

730 Camberly Circle A4

10f. Zip Code

21204

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George M. Suter

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Mallone

19a. Informant's Name/Relationship (Type, Print)

Beverly Roesler/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

730 Camberly Circle Apt. A4 Towson, MD 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

01/28/2004

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cerebrovascular Accident

Approximate Interval Between Onset and Death  
2 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Hypertensive Cerebrovascular Disease

Years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End-Stage Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined7 ☐ Pending investigation8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert E. Roby, M.D.

29c. License number

D-19425

29d. Date signed (Month, Day, Year)

1/26/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert E. Roby, MD, 2211 W. Rogers Ave. Baltimore, Md. 21209

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01916

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances

Weiner

2. Date of Death

January 24 2004

3. Time of Death

09:04 AM

4a. Facility Name (If not institution, give street and number)

Howard County General Hosp.

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

215-18-6538

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

8. Date of Birth

MAY 9 1920

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6705 CHOKEBERRY ROAD

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

AARON

COPELAND

18. Mother's Name (First, Middle, Maiden Surname)

FLORA

HARRIS

19a. Informant's Name/Relationship (Type, Print)

MR. MORTON WEINER/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6705 CHOKEBERRY ROAD BALTIMORE, MD. 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematorium, or other place)

BETH JACOB CONG.

Date

1/25/2004

20c. Location - City or Town, State

FINKSBURG, MD.

21. Signature of Funeral Service Licensee

BETH JACOB CONG.

22. Name and Address of Facility

SOL LEVINSON & BROS. INC  
8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Septic Shock

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
multiple myelomab. Due to (or as a consequence of):  
Chronic renal failure

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dilated cardiomyopathy  
Congestive heart failure  
dehiscence incision

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Suzan Abdo

29c. License number

D50870

29d. Date signed (Month, Day, Year)

January 24 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suzan Abdo 5005 Signal Bell Ln. Clarksville MD 21029

31. Date filed (Month, Day, Year)

JAN 27 2004

32. Registrar's Signature

Suzan Abdo

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2004 01917

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Julia Lee Walker

2. Date of Death

January 19, 2004 12:34 A.M.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2220 Walbrook Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212-22-5021

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Greenville, S.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2220 Walbrook Avenue

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Spring Grove Mental Institution

17. Father's Name (First, Middle, Last)

John Lomax

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Barton

19a. Informant's Name/Relationship (Type, Print)

Shelley D. Walker/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2220 Walbrook Avenue Baltimore, MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

1/26/04

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

Leroy Harris

22. Name and Address of Facility

Charmen-Harris Funeral Home 5240-44 Reisterstown Road Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Carcinoma of Unknown Primary

Approximate Interval Between Onset and Death

1 yr

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Paul Gormley MD

29c. License number

D18587

29d. Date signed (Month, Day, Year)

JAN 22 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL GORMLEY 900 CATON AVE BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

JAN 26 2004

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Lindberg Ulysses Wade, Sr.  
unknown 04-020  
04-00509  
DOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Unpend Item #231827

per me 6826 2/24/04 tas

Certificate of Death

Reg. No.

2004 01918

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LINDBERG Ulysses Wade

2. Date of Death  
Month Day Year  
January 18 2004

3. Time of Death  
1307 p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Maryland General

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

MD

5. Social Security Number

212 70 6394

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 18, 1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

MD

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3412 Park Heights Ave

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
8<sup>th</sup> grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

James Wade

18. Mother's Name (First, Middle, Maiden Surname)

Louise Brown

19a. Informant's Name/Relationship (Type, Print)

Rosalie Matthews / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2719 Owego Ave Baltimore Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion Cemetery

Date

1/24/04

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

Spay Hammer

22. Name and Address of Facility

CRAMA - Home Health Care  
5440 RENTON RD  
BALTIMORE MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

Sepsis Due To Chronic Narcotism

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown

3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Therese M. Ukele MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

January 19 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD Regs MD P. KORSER

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 26 2004

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend Item #5 per informant G831 5/12/04 tas

Certificate of Death

Reg. No.

2004 01919

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Laura Catherine Ximines</b>				2. Date of Death Month <b>January</b> Day <b>14</b> Year <b>2004</b>		3. Time of Death <b>10:15am</b>	
4a. Facility Name (If not institution, give street and number) <b>FOREST HAVEN NURSING HOME</b>				4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>116-18-4063</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR. 14, 1908</b>	
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>CATONSVILLE</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>701 EDMONDSON AVENUE</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S. OF A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6TH GRADE</b> College (1-4 or 5+) <b>UNKNOWN</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SUPERVISOR</b>		16b. Kind of Business/Industry <b>METAL WORKS FACTORY</b>			
17. Father's Name (First, Middle, Last) <b>ROBERT TAYLOR (DECEASED)</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROSEY WHITEN TAYLOR BELL (DECEASED)</b>			
19a. Informant's Name/Relationship (Type, Print) <b>DR JACALYN BLACKWELL-WHITE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>GREAT GRAND NIECE 9145 STAYMAN DR. ELLICOTT CITY, MD. 21042</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK</b>		Date <b>1/22/04</b>		20c. Location - City or Town, State <b>ARBUTUS, MARYLAND</b>	
21. Signature of Funeral Service Licensee <b>Lewis T. Gwynn</b>				22. Name and Address of Facility <b>LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVENUE BALTO., MD.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. <b>ATHEROSCLEROTIC CEREBROVASCULAR DISEASE</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>Jasneem Saleem</b>				29c. License number <b>D 28595</b>		29d. Date signed (Month, Day, Year) <b>1/15/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TASNEEM LAKHTANI, 7220 PARK HEIGHTS AVE, BALTO MD 21208</b>							
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>				32. Registrar's Signature <b>B Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01920

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Richard Lee Yeagle, Sr.</b>		2. Date of Death Month <b>January</b> Day <b>23</b> Year <b>2004</b>		3. Time of Death <b>10:35 A<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>		4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>213-03-4080</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Nov. 23, 1910</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>10 Gorsuch Road</b>		10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Purchasing Agent</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Purchasing Agent</b>		16b. Kind of Business/Industry <b>Koppers Company</b>	
17. Father's Name (First, Middle, Last) <b>Lawrence G. Yeagle</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Burgee</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Charlotte M. Yeagle/wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 Gorsuch Road Timonium, Maryland 21093</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Mem. Gardens</b>		20c. Location - City or Town, State <b>Timonium, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>END STAGE DEMENTIA</b> Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  29c. License number <b>D43725</b> 29d. Date signed (Month, Day, Year) <b>1/23/04</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>					
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b> 32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 01921

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT J. ZUCHOWSKI, SR.</b>				2. Date of Death Month <b>January</b> Day <b>21</b> Year <b>2004</b>		3. Time of Death <b>3:13 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>UPPER CHESAPEAKE</b>				4b. City, Town, or Location of Death <b>BEL AIR</b>		4c. County of Death <b>TOWSON</b>		
Funeral Director	5. Social Security Number <b>212-32-5844</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUNE 28, 1935</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>HARFORD</b>	10c. City, Town or Location <b>BEL AIR</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>2018 HARFORD ROAD</b>			10f. Zip Code <b>21047</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SUPERINTENDANT</b>		16b. Kind of Business/Industry <b>CHARLES TOWN RACE TRACK</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>JOSEPH ZUCHOWSKI</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY ZUCHOWSKI</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>TRENT S. ZUCHOWSKI</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2018 HARFORD ROAD FALLSTON MARYLAND 21047</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>2-STAR FUNERAL HOME JAN. 23, 2004 BEL AIR, P.A.</b>		20c. Location - City or Town, State <b>FOREST HILL MARYLAND</b>				
	21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>ST. ANNE'S CHURCH - BEL AIR, P.A. 21038 30 NEWPORT DRIVE FOREST HILL MARYLAND</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE METABOLIC ACIDOSIS</b> Due to (or as a consequence of): <b>b. ACUTE RENAL FAILURE</b> Due to (or as a consequence of): <b>c. HYPOTENSION</b> Due to (or as a consequence of): <b>d.</b>								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				
	23d. Date of delivery Month Day Year				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE STENOSIS</b> <b>ATRIAL FLUTTER</b> <b>PULMONARY HYPERTENSION</b>								
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>[Signature]</b>				
	29c. License number <b>HSS922</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 21, 2004</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANTHONY W. SAMPHILO DO. 500 UPPER CHESAPEAKE DR, BEL AIR, MD 21014</b>								
31. Date filed (Month, Day, Year) <b>JAN 27 2004</b>								32. Registrar's Signature <b>[Signature]</b>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01922

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine Anthony</b>				2. Date of Death Month Day Year <b>01 22 2004</b>		3. Time of Death <b>6:05 P M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Bon Secours Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>220-22-6693</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12 09 22</b>	
	9. Birthplace (State or Foreign Country) <b>VA</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>2221 Bryant Ave</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>na</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>Private Home</b>				
17. Father's Name (First, Middle, Last) <b>Pansy Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucille Smith</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Delores Lee-Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7926 Dunhill Village Circle, #204, Baltimore MD 21244</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. 1/30/04 Owings Mills, Md</b>		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee <b>Hebe...</b>		22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore Md 21215</b>						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one on each line. <b>Septic Shock</b>		a. Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		d. Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pancreatic Carcinoma</b>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>H. Neal Reynolds MD</b>		29c. License number <b>D27163</b>		
29d. Date signed (Month, Day, Year) <b>1/22/04</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>H. Neal Reynolds, Bon Secours Hospital of Baltimore</b>		31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature <b>...</b>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01923

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen</b>		2. Date of Death Month <b>January</b> Day <b>25</b> Year <b>2004</b>		3. Time of Death <b>16:26 M</b>
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>237 32 1048</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>April 10, 1923</b>	9. Birthplace (State or Foreign Country) <b>N.C.</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1807 Rutland Ave</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic work</b>		16b. Kind of Business/Industry <b>Domestic work</b>
	17. Father's Name (First, Middle, Last) <b>Fred Howard</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie Perkins</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Risa Crenshaw</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3829 Rutland Ave Baltimore MD 21213</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>
	21. Signature of Funeral Service Licensee <b>Patricia Betts</b>		22. Name and Address of Facility <b>PETS Funeral Home</b> <b>1129 N. Caroline St Baltimore MD 21213</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Aspiration pneumonia</b> Due to (or as a consequence of): b. <b>stroke</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>1 week.</b> <b>4 months</b>				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic kidney disease, diabetes mellitus,</b> <b>chronic obstructive pulmonary disease</b> 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 26. Place of Death (Check only one) 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier <b>Rizwan Haq MD</b> 29c. License number <b>RES-020</b> 29d. Date signed (Month, Day, Year) <b>January 25, 2004</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rizwan Haq, 600 North Wolfe Street, Baltimore, MD 21287</b>					
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b> 32. Registrar's Signature <b>Rizwan Haq</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

## Certificate of Death

Reg. No. 2004 01924

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRVING APPLEFELD.

2. Date of Death

JANUARY 22 2004 6:40 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER RANDALLSTOWN

4b. City, Town, or Location of Death

4c. County of Death

BALTIMORE

5. Social Security Number

217-05-3731

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG 4, 1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD10b. County  
BALTIMORE10c. City, Town or Location  
BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

725 MT. WILSON LANE #701

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ATTORNEY

16b. Kind of Business/Industry

AT LAW

17. Father's Name (First, Middle, Last)

LOUIS

APPLEFELD

18. Mother's Name (First, Middle, Maiden Surname)

ETTA

(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

MR. MICHAEL APPLEFELD/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 WILLOW OAKS CIRCLE BALTIMORE, MD. 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
Cemetery, Crematorium, or other place)ARLINGTON CHURCH  
AMONG CONG.

Date

1/25/2004

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Scott M. Cuthbert

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.  
8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208Physician  
/Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ADENOCARCINOMA OF LUNGS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE  
PNEUMONIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and Title of certifier

Scott M. Cuthbert PHYSICIAN

29c. License number

D42723

29d. Date signed (Month, Day, Year)

JANUARY 22 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANVERA HALL HARISIA

NORTHWEST HOSPITAL CENTER  
5401 OLD COURT ROAD MD 21133

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Benjamin B Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01925

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Narcissis Jane Beam						2. Date of Death Month Day Year January 13, 2004		3. Time of Death 5:50 PM		
	4a. Facility Name (If not institution, give street and number) Hillhaven Nursing Home						4b. City, Town, or Location of Death Adelphi		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 251-34-0617		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Dec 30, 1927		9. Birthplace (State or Foreign Country) South Carolina		
	Usual Residence of Decedent										
10a. State MD		10b. County Prince George's		10c. City, Town or Location Adelphi				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 3121 Powder Mill Road				10f. Zip Code 20783				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Robert Parker						18. Mother's Name (First, Middle, Maiden Surname) Mamie Belue					
19a. Informant's Name/Relationship (Type, Print) Alfred Beam Husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3121 Powder Mill Road Adelphi, MD 20783					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Grove Bapt. Ch. Cem. 1-17-04		Date Landrum, SC		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Petty Funeral Home 124 N. Trade Street Landrum, SC 29356					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Parkinson's Disease - End Stage Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Atrial Fibrillation								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number D0053337		29d. Date signed (Month, Day, Year) January 20, 2004			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dorothy Seay, M.D. 10801 Lockwood Dr., Silver Spring, MD 20901											
31. Date filed (Month, Day, Year) JAN 28 2004				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68768

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01926

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Muriel B. Beatty

2. Date of Death

January 26 2004

3. Time of Death

9:15 PM

4a. Facility Name (If not institution, give street and number)

816 Riverside Drive

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

5. Social Security Number

213-76-0610

6. Sex

☐ M ☒ F

7. Age (in yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 10 1917

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

816 Riverside Drive

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. Do NOT use retired)

Homemaker

16b. Kind of Business/Industry

Household

17. Father's Name (First, Middle, Last)

Clarence P. Harrison

18. Mother's Name (First, Middle, Maiden Surname)

Virginia M. Blair

19a. Informant's Name/Relationship (Type, Print)

Robert E. Beatty (spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

816 Riverside Drive, Pasadena, MD 21122

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Cemetery

Date

Jan. 31 2004

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stallings Funeral Home, P.A.  
3111 Mountain Road, Pasadena, MD 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Approximate Interval Between Onset and Death

X One year

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic Heart Disease

months

Due to (or as a consequence of):

c. Atrial Fibrillation

X 2 years

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Malabsorption syndrome  
- small bowel resection

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Salvador D. Ramirez

29c. License number

00038912

29d. Date signed (Month, Day, Year)

01/27/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Salvador D. Ramirez

7845 Oakwood Road Suite 307

Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Jennifer Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68766

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01927

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BARBARA JEANNE BRESENHAN

2. Date of Death

Month Day Year  
JANUARY 24, 2004

3. Time of Death

11:23 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

706 BROADVIEW BOULEVARD

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

232-50-4752

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC. 23, 1931

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

706 BROADVIEW BOULEVARD

10f. Zip Code

21061

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JAMES B. BROGAN

18. Mother's Name (First, Middle, Maiden Surname)

ALICE GRIFFITH

19a. Informant's Name/Relationship (Type, Print)

TIMOTHY BRESENHAN - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

706 BROADVIEW BOULEVARD GLEN BURNIE, MARYLAND 21061

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOWRIDGE MEM. PK.

JANUARY 29

2004

20c. Location - City or Town, State

ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

KIRKLEY-RUDDICK FUNERAL HOME P.A.  
421 CRAIN HIGHWAY S.E. GLEN BURNIE, MARYLAND 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. alzheimer's Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

contractures of all extremities  
dysphagia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death Check only one

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D41955

29d. Date signed (Month, Day, Year)

1-26-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rebecca Eton MD 8601 Veterans Highway #204 Millersville MD 21108

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01928

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MARY LOUISE BULLUCK

2. Date of Death

January 24 2004

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

225 24 9781

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

78

8. Date of Birth

4/7/25

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD.

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4012 ARAGON AVE.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER (NURSING)

16b. Kind of Business/Industry

COPPIN STATE

17. Father's Name (First, Middle, Last)

WILMER COBBS

18. Mother's Name (First, Middle, Maiden Surname)

NATHLIE BROWN

19a. Informant's Name/Relationship (Type, Print)

MALCOLM COBBS BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2525 W. FOREST PARK AVE. BALTO. MD. 21215

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

1/26/04

20c. Location - City or Town, State

CATONSVILLE, MD.

21. Signature of Funeral Service Licensee

C.A. ESTEP

22. Name and Address of Facility

ESTEP BROS. FUNERAL HOME P.A.  
1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Hemorrhage

Approximate Interval Between Onset and Death  
3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus type 2  
Arterial Hypertension

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. C. T. M. D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAOLO FABRIZIO CAIMI

2401 W. Belvedere Ave Baltimore, MD 21215

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

P. C. T. M. D.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Patient Known as Bulluck, Mary  
Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01929

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner	Funeral Director	To Be Completed by Funeral Director	To Be Completed by Physician/Medical Examiner	Physician /Medical Examiner	State Registrar

1. Decedent's Name (First, Middle, Last) RENATA BERRY			2. Date of Death Month Day Year JANUARY 22 2004			3. Time of Death 10:05 A M				
4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER 30015 HANNOVER ST			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death BALTIMORE				
5. Social Security Number 219-68-1647		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) 4-5-1963		9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent										
10a. State MD		10b. County Balto. Co.		10c. City, Town or Location Randallstown			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 7213 Rutherford Green Circle			10f. Zip Code 21244			10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unknown			16b. Kind of Business/Industry Unknown				
17. Father's Name (First, Middle, Last) Clifton Berry			18. Mother's Name (First, Middle, Maiden Surname) Cora Berry							
19a. Informant's Name/Relationship (Type, Print) Brendia Carrington			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 7213 Rutherford Green Circle Randallstown							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem.Park			Date 1-29-2004		20c. Location - City or Town, State Arbutus MD		
21. Signature of Funeral Service Licensee E.N.Walker Jr			22. Name and Address of Facility Estep Bros. Funeral Serv. P.A. 1300 Eutaw PL. Baltimore MD 21217							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPTIC SHOCK - MRSA SEPSIS Due to (or as a consequence of): b. MULTIORGAN DYSFUNCTION Due to (or as a consequence of): c. DIC - GI BLEED Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 48 hours										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. IVDA			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier MD			29c. License number P16774		29d. Date signed (Month, Day, Year) 1/22/04		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUDIVARAH ARCHANA, HARBOR HOSPITAL CENTER, 30015 HANNOVER ST										
31. Date filed (Month, Day, Year) JAN 28 2004			32. Registrar's Signature B. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 5 per FH,G827,01/30/04dhb

## Certificate of Death

Reg. No. 2004 01930

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clara</b>						2. Date of Death Month Day Year <b>JANUARY 21, 2004</b>		3. Time of Death <b>2:40 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hospital</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death		
Funeral Director	5. Social Security Number <b>231-50-1881</b> <b>231-51-1881</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11 12 30</b>		9. Birthplace (State or Foreign Country) <b>NC</b>		
	Usual Residence of Decedent						10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>315 Martingale Ave</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th grade</b> College (1-4or 5+) <b>na</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Home</b>			
	17. Father's Name (First, Middle, Last) <b>Jessie Lucas</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Pittman</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Cresel Moore-Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9104 Vega Ct, Randallstown, Md 21133</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>			20c. Location - City or Town, State <b>1/27/04 Randallstown, Md</b>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>PULMONARY ATELECTASIS + BILATERAL INFILTRATES</b> <b>2 WKS</b> Due to (or as a consequence of):  b. <b>PULMONARY TUBERCULOSIS</b> <b>7 MONTHS</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>CIRRHOSIS</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined						28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D 52540</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 23, 2004</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ST. AGNES HEALTHCARE 900 CATON AVE BALTIMORE, MD 21229</b>											
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>						32. Registrar's Signature <i>[Signature]</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01931

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) John Thornton Berger  
2. Date of Death Month Day Year JAN. 21, 2004  
3. Time of Death 12:15 PM

Funeral Director

4a. Facility Name (If not institution, give street and number) 706 S. BAYLIS STREET  
4b. City, Town, or Location of Death BALTIMORE CITY  
4c. County of Death N/A  
5. Social Security Number 215-30-8214  
6. Sex ☒ M ☐ F  
7. Age (In yrs. last birthday) 68 Yrs.  
8. Date of Birth (Month, Day, Year) Dec. 28, 1935  
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent  
10a. State Maryland  
10b. County N/A  
10c. City, Town or Location Baltimore  
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 706 S Baylis Street  
10f. Zip Code 21224  
10g. Citizen of What Country? United States

11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced  
12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:  
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 12 yrs  
College (1-4 or 5+) College (1-4 or 5+)  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder  
16b. Kind of Business/Industry Steel

17. Father's Name (First, Middle, Last) Albert M. Berger  
18. Mother's Name (First, Middle, Maiden Surname) Helen M. Thornton

19a. Informant's Name/Relationship (Type, Print) Sandie Castle/daughter  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 W. 38th Street Baltimore, Maryland 21211

20a. Method of Disposition  
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.  
Date 1/23/2004  
20c. Location - City or Town, State Towson, Maryland

21. Signature of Funeral Service Licensee *Stephanie Massey*  
Name and Address of Facility Huda-Ruck Funeral Home of Dundalk, Inc  
7922 Wise Avenue, Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest.  
Immediate Cause (Final disease or condition resulting in death) a. *atherosclerotic cardiovascular disease*  
Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):  
Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  
IF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown  
23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown  
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown  
24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No  
24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
☒ Yes 2 ☐ No  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE  
27. Manner of Death  
1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29b. Signature and title of certifier *Patricia Aronica Pollock*  
29c. License number O.C.M.E  
29d. Date signed (Month, Day, Year) JAN. 22, 2004  
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Aronica Pollock, 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) JAN 28 2004  
32. Registrar's Signature *John Berger*

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01932

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jeanette Louise Blankenship

2. Date of Death

Month Day Year JANUARY 23, 2004

3. Time of Death  
4:50 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-12-1876

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 11, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Glen Arm

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11541 Long Green Pike

10f. Zip Code

21057

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Internal Auditor

16b. Kind of Business/Industry

Blue Cross &amp; Blue Shield

17. Father's Name (First, Middle, Last)

George Washington Heise

18. Mother's Name (First, Middle, Maiden Surname)

Eva J. Dyke

19a. Informant's Name/Relationship (Type, Print)

Bruce A. Emmel/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16501 Magnolia Court Colesville, MD 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parkwood Cemetery

Date

1/28/04

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee Christina L. Hilton

Christina L. Hilton

22. Name and Address of Facility

Leonard J. Ruck, Inc. 5305 Harford Road  
Baltimore Maryland 2121423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. SEPSIS

Due to (or as a consequence of):

ADVANCED INTERSTITIAL LUNG DISEASE

b. Due to (or as a consequence of):

c. CLOSTRIDIUM DIFFICILE COLITIS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ OOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joginder P. Mehta M.D.

29c. License number

D 0041410

29d. Date signed (Month, Day, Year)

January 23rd, 2004.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01933

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) William Laverne Bennett				2. Date of Death Month Day Year January 23, 2004		3. Time of Death 6:55 PM	
4a. Facility Name (If not institution, give street and number) Riverview Nursing Center				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore Co.	
5. Social Security Number 218-01-3728		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 24, 1916	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 902 Virginia Avenue				10f. Zip Code 21221		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aircraft Mechanic		16b. Kind of Business/Industry Martins Aerospace	
17. Father's Name (First, Middle, Last) William L. Bennett				18. Mother's Name (First, Middle, Maiden Surname) Florence Harrison			
19a. Informant's Name/Relationship (Type, Print) Ms. Cathy Bennett (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Virginia Ave. Essex, Maryland 21221			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 1/27/2004		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee <i>E. Reed</i>				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;">                     Immediate Cause (Final disease or condition resulting in death)                       Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                 </div> <div style="width: 60%;">                     a. Probable acute Myocardial infarction                      Due to (or as a consequence of):                      b. Coronary artery Disease                      Due to (or as a consequence of):                      c.                      Due to (or as a consequence of):                      d.                 </div> <div style="width: 10%;">                     Approximate Interval Between Onset and Death                      2-3 hrs                      un-known                 </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimers Dementia, HTN Chronic atrial fibrillation.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>M. Reed M.D.</i>				29c. License number D-38754		29d. Date signed (Month, Day, Year) 01-24-2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALIKA WASBAM. 709. EASTERN BLVD - MD - 21221							
31. Date filed (Month, Day, Year) JAN 28 2004				32. Registrar's Signature <i>[Signature]</i>			

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01934

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Barner Jr.

2. Date of Death  
Month Day Year

JANUARY 23 2004

3. Time of Death

0752 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SAINT AGNES HEALTHCARE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

246-24-4996

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 29, 1927

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State  
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4415 Rokeby Rd.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

City of Baltimore

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Sumame)

unknown

19a. Informant's Name/Relationship (Type, Print)

Lengra Barner - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4415 Rokeby Rd. Baltimore, Maryland 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet. Cem.

Date

1/29/04

20c. Location - City or Town, State

Owing Mills Maryland

21. Signature of Funeral Service Licensee

Kevin Parker

22. Name and Address of Facility

Parker Chavis & Cranford F.S. P.A.  
3512 Frederick Ave. Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Approximate Interval Between Onset and Death

twelve hours

Due to (or as a consequence of):

b. METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS PNEUMONIA

Due to (or as a consequence of):

c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

d. CHRONIC RESPIRATORY FAILURE

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

PERIPHERAL VASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jonathan Safren MD ATTENDING PHYSICIAN

29c. License number

MARYLAND

29d. Date signed (Month, Day, Year)

D0041711 JANUARY 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN SAFREN MD 3449 WILKENS AVE SUITE 300 BALTIMORE, MARYLAND 21229

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Benjamin B. Spence

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 01935  
Certificate of Death

1- For State Registrar

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

JESSE H. BENSON, JR.

2. Date of Death

Month Day Year  
JANUARY 20 2004

3. Time of Death

18:00 P M

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER, 3001 SHANNON ST

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

5. Social Security Number

219 30 2962

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 14, 1933

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

20 W. Talbot Street

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

Balto. City Police Dept.

17. Father's Name (First, Middle, Last)

Jesse Benson Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Wratchford

19a. Informant's Name/Relationship (Type, Print)

Yvonne Benson / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 West Talbot Street Baltimore, Maryland 21225

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Cemetery

Date

1/24/2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*Dana M. Zmorski*

22. Name and Address of Facility

George J. Gonce Funeral Home, P.A.  
4001 Ritchie Highway Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GI bleed

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Emphysema

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

9 hours

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No

☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death

☐ Pregnant at time of death

☐ Unknown

☐ Ectopic pregnancy

☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery Disease, MI

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*H. A. ... MD*

29c. License number

P16774

29d. Date signed (Month, Day, Year)

1/20/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIJIVARTHI ARCHANA, HARBOR HOSPITAL CENTER, 3001 HANNOVER ST

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01936

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JUNE BAKER

2. Date of Death

Jan. 20 2004

3. Time of Death

4:45 PM

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE

4b. City, Town, or Location of Death

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214 54 9280

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 10, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6504 Homewater Court Suite 303

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Accounts Receivable &amp; Pay.

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Kenneth Barlow

18. Mother's Name (First, Middle, Maiden Sumame)

Donna (not available)

19a. Informant's Name/Relationship (Type, Print)

Thomas Baker / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6504 Homewater Court Suite 303 Glen Burnie, MD. 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Mem. Park

Date

1/23/2004

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Dana M. Zimorski

22. Name and Address of Facility

George J. Gonce Funeral Home, P.A.  
4001 Ritchie Highway Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE MYELOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

HYPERVOLEMIA

THROMBOCYTOPENIA, FEVER

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Gorgun Akpek M.D.

29c. License number

D 59766

29d. Date signed (Month, Day, Year)

Jan/20/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GORGUN AKPEK M.D. GREENEBAUM CANCER CENTER AT UNIVERSITY OF MARYLAND.

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01937

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Harold Roland Carter

2. Date of Death

January 22 2004

3. Time of Death

10<sup>55</sup> P M

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral Director

5. Social Security Number

228-18-1615

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 14, 1918

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9820 Clanford Road

10f. Zip Code

21133

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Contractor

16b. Kind of Business/Industry

Carter Construction

17. Father's Name (First, Middle, Last)

James Edward Carter

18. Mother's Name (First, Middle, Maiden Surname)

Albenia Gaskins

19a. Informant's Name/Relationship (Type, Print)

Lucille Rich - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9820 Clanford Road Randallstown, MD 21133

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cem.

Date

1/31/04

20c. Location - City or Town, State

Balto. Co., MD

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.  
2501 Gwynns Falls Pkwy. Balto., MD 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute respiratory acidosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

2 days

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☐ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure  
Coronary artery disease  
Congestive heart failure

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Harland

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

January 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mariya F. Harland, MD Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

[Signature]

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01938

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna A. Carlino

2. Date of Death

Month Day Year  
January 26, 2004

3. Time of Death

2:15 P M

4a. Facility Name (If not institution, give street and number)

Holly Hill Nursing Home

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

069-01-2845

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 23, 1909

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10535 York Road

10f. Zip Code

21030

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Angerame

18. Mother's Name (First, Middle, Maiden Surname)

Rose Falciglia

19a. Informant's Name/Relationship (Type, Print)

Charles Carlino/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Alderman Ct., Timonium, MD 21093

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

Jan 28  
2004

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Stephen D. Schumann

MOO382

22. Name and Address of Facility

Cremation and Funeral Alternatives  
8717 Green Pastures Drive Baltimore, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer with metastasis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cachexia

Due to (or as a consequence of):

1 Yr

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death ☐ Other (specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mian Por Kizung, m p

29c. License number

D31505

29d. Date signed (Month, Day, Year)

1/27/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rm 206 521 N. Guntaw street Baltimore Md 21201

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01939

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Robert R. Collins, Jr.

2. Date of Death

January 22, 2004

3. Time of Death

6:15 AM

4a. Facility Name (If not institution, give street and number)

Lorien Nursing and Rehabilitation Center

4b. City, Town, or Location of Death

Mount Airy

4c. County of Death

Carroll

5. Social Security Number

216-05-9888

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91

8. Date of Birth (Month, Day, Year)

Mar. 15 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

713 Midway Avenue

10f. Zip Code

21779

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

LA Benson Co.

17. Father's Name (First, Middle, Last)

Robert R. Collins, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Alice Woolsey

19a. Informant's Name/Relationship (Type, Print)

Joyce DiDio / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1429 Chessie Ct. Mt. Airy, Maryland 21779

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cem.

Date

1-24-04 Balt., Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Ave., Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ANTERIOSCLECTIC CARDIOVASCULAR DISEASE

15 Yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work? ☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician  
☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULIO MEYER MD 1564 OPOSUMTOWN PIKE FREDERICK, MD 21702

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01940

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505C.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) WILLIAM M. CUBBAGE		2. Date of Death Month Day Year JANUARY 26, 2004		3. Time of Death 12:34 AM	
4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER		4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
5. Social Security Number 249-38-2092	6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	8. Date of Birth (Month, Day, Year) MARCH 2, 1928	9. Birthplace (State or Foreign Country) SOUTH CAROLINA	
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 701 GLENWOOD STREET APT. 718		10f. Zip Code 21401	
10g. Citizen of What Country? UNITED STATES		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) SELF EMPLOYED	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED		16b. Kind of Business/Industry RETAIL SALES		17. Father's Name (First, Middle, Last) LEIGHTON CUBBAGE	
18. Mother's Name (First, Middle, Maiden Surname) ROBERTA ANDREWS		19a. Informant's Name/Relationship (Type, Print) RONALD J. CUBBAGE - SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3719 BUCKINGHAM ROAD BALTIMORE, MARYLAND 21207	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Location - City or Town, State JANUARY 27 2004 CATONSVILLE, MARYLAND	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility KRYLEY-RODDER FUNERAL HOME P.A. 21061 421 CRAIN HIGHWAY S.E. GLEN BURNIE, MARYLAND			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Emphysema		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier Sperber, RW	
29c. License number D46052		29d. Date signed (Month, Day, Year) 1/26/04		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sperber, RW 2001 Medical Parkway, Annapolis, MD	
31. Date filed (Month, Day, Year) JAN 28 2004		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01941

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>KATHLEEN CAZLEY</b>		2. Date of Death Month Day Year <b>JANUARY 18 2004</b>		3. Time of Death <b>03:55 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death	
5. Social Security Number <b>127-46-2861</b>	6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	8. Date of Birth (Month/Day, Year) <b>10/15/1934</b>		9. Birthplace (State or Foreign Country) <b>Jamaica</b>
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Columbia</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>10290 Day StarCourt</b>		10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Lic. Practial Nurse</b>		16b. Kind of Business/Industry <b>Health Care</b>			
17. Father's Name (First, Middle, Last) <b>Raubert Cazley</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Isabelle Campbell</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Ena Hibbert/daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7310 Cedar Ave., Jessup, Md. 20794</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Columbia Mem. Park</b>		20c. Location - City or Town, State <b>01/24/2004 Clarksville, Md.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd., Columbia, MD. 21045</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>HEART FAILURE</b>		Approximate Interval Between Onset and Death <b>1 DAY</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>SEPSIS</b>		<b>25 DAYS</b>	
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 18, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PRASHANTH VALLABHAJOSYULA 600 NORTH WOLFE STREET, BALTIMORE MARYLAND 21287</b>					
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #8 PER FH G828 2/04/04 Certificate of Death

Reg. No.

2004 01942

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>RICKEY CHATMAN</b>		2. Date of Death Month <b>1</b> Day <b>20</b> Year <b>2004</b>		3. Time of Death <b>11:15 A M</b>	
4a. Facility Name (If not institution, give street and number) <b>6001 MUNCASTER MILL RD</b>		4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>432-02-3256</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>8-31-1954</b>	9. Birthplace (State or Foreign Country) <b>Wilmont, AK</b>	
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>SILVER SPRING</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1131 UNIVERSITY BLVD W. # 602</b>		10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>1 yr</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Telephone Technician</b>		16b. Kind of Business/Industry <b>Private</b>	
17. Father's Name (First, Middle, Last) <b>James Chatman</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Fern Evans</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Fern O. Finley/Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1131 University Blvd. W. # 602 Silver Spring, Md 20902</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Riverdale Crematory</b>		20c. Location - City or Town, State <b>1-23-04 Riverdale, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>LUNG CANCER</b>					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)					
Sequentially list conditions, if any, leading to immediate cause, either disease, injury, Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D35635</b>		29d. Date signed (Month, Day, Year) <b>1-20-04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSEPH KAPLAN M.D. 6001 Muncaster Mill Rd. Rockville, Maryland 20902</b>					
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature 			

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01943

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Patrick J. Channell

2. Date of Death

January 20, 2004

3. Time of Death

10:55 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore city

4c. County of Death

N/A

5. Social Security Number

217 34 5039

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 21, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Willards

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

36133 Poplar Neck Road

10f. Zip Code

21874

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1955-5813. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Maintainer

16b. Kind of Business/Industry

Crown Cork &amp; Seal

17. Father's Name (First, Middle, Last)

Patrick Jefferson Channell

18. Mother's Name (First, Middle, Maiden Surname)

Frances Polcak

19a. Informant's Name/Relationship (Type, Print)

Audrey Channell / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36133 Poplar Neck Road Willards, Maryland 21874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Loudon Park Cemetery 1/26/2004 Baltimore, Maryland

21. Signature of Funeral Service Licensee

George J. Gonce Funeral Home, P.A.

22. Name and Address of Facility

4001 Ritchie Highway Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Hypotension

Due to (or as a consequence of):

b. Upper Gastrointestinal bleed

Due to (or as a consequence of):

c. Cirrhosis

Due to (or as a consequence of):

d. Hepatitis C infection

Approximate  
Interval Between  
Onset and Death

2 hours

16 hours

3 years

10 years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David C. MD

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

January 21, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID COSGROVE, JOHNS HOPKINS HOSPITAL, 600 N. WOLFE STREET, BALTIMORE, MARYLAND 21287

31. Date filed (Month, Day, Year)

JAN 20 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01944

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505C.

Division of Vital Records, P.O. Box 68766

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Marguerite Skyles Craft</b>		2. Date of Death Month <b>January</b> Day <b>18</b> Year <b>2004</b>		3. Time of Death <b>10:40 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>232-44-7495</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Feb. 23, 1919</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>Cottage #29 7431 Willow Road</b>		10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>			
17. Father's Name (First, Middle, Last) <b>Henry Moffitt Harlow</b>			18. Mother's Name (First, Middle, Maiden Sumame) <b>Lucy Mabel Clark</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Albert O. Craft -</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Cottage #29 7431 Willow Rd., Frederick, MD 21702</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Spring Hill Cemetery</b>		20c. Location - City or Town, State <b>1-23-04 Huntington, WV</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Klingel-Carpenter Mortuary 328 6th Ave. Huntington, WV 25701</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Coronary Artery Disease</b> Due to (or as a consequence of): <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
23b. If FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b> <b>malnutrition</b>					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D036610</b>		29d. Date signed (Month, Day, Year) <b>1/19/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Edward F. Fisher MD 56 Thomas Johnson Dr. Frederick MD</b>					
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01945

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William T. Clisham</b>		2. Date of Death Month <b>January</b> Day <b>23</b> Year <b>2004</b>		3. Time of Death <b>12:49P M</b>
	4a. Facility Name (If not institution, give street and number) <b>305 E. Joppa Road Apt. 703</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>216-30-7489</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>69</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>August 1, 1934</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Towson</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>305 E. Joppa Road Apt. 703</b>		10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Korea</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>		16b. Kind of Business/Industry <b>Cat Motor Sales</b>		
	17. Father's Name (First, Middle, Last) <b>Timothy Clisham</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Bulman</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Joanne Brunsmann/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5502 Walther Avenue Baltimore Maryland 21214</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. Cem.</b>		20c. Location - City or Town, State <b>1/30/04 Owings Mills Maryland</b>
	21. Signature of Funeral Service Licensee <b>Christina L. Hilton</b>		22. Name and Address of Facility <b>Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CORONARY ARTERY DISEASE</b> <b>OSTEOARTHRITIS</b>					
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
26. Place of Death (Check only one) 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury <b>M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Dr. Fernando J. Ferro</b> 29c. License number <b>D40480</b> 29d. Date signed (Month, Day, Year) <b>JANUARY 23, 2004</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FERNANDO J. FERRO, MD</b> <b>7672 BELAIR ROAD</b> <b>BALTIMORE, MD 21236</b>					
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b> 32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01946

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Albert Duban

2. Date of Death

1 21 2004 5:12 P M

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

BALTIMORE

5. Social Security Number

217-22-4135

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sep 13, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 Brett Court, Apt. 216

10f. Zip Code

21221

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 46-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Employee

16b. Kind of Business/Industry

State Highway Administration

17. Father's Name (First, Middle, Last)

August Duban

18. Mother's Name (First, Middle, Maiden Surname)

Frances Rominski

19a. Informant's Name/Relationship (Type, Print)

Mrs. Karen Fellner/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5216A Forge Road, Perry Hall, MD 21128

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

Jan 24 2004

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

J. Hulett 100986

22. Name and Address of Facility

Cremation and Funeral Alternatives  
8717 Green Pastures Drive Baltimore, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. M I

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease

Renal Failure

DM

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Hulett

29c. License number

D28717

29d. Date signed (Month, Day, Year)

1-21-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Stephen Selinger 9000 FRANKLIN SQUARE DR. BALTIMORE MD 21237

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

James A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01947

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) KATHERINE H. DAVIS				2. Date of Death Month Day Year JANUARY 23 2004		3. Time of Death 8:10 PM	
4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
5. Social Security Number 217-22-7400		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 12 1918	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State Md.		10b. County Anne Arundel Co.		10c. City, Town or Location Pasadena		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 1635 Lakewood Road				10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) George Wicklein				18. Mother's Name (First, Middle, Maiden Surname) Hazel Brooke			
19a. Informant's Name/Relationship (Type, Print) Raymond A. Davis (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1635 Lakewood Road, Pasadena, Md. 21122			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 01/28/04		20c. Location - City or Town, State Baltimore, Md.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. EMPHYSEMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier  MD				29c. License number 00055973		29d. Date signed (Month, Day, Year) JANUARY 23, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zeieke Berse 11500 Sutherland Hill Way Silver Spring MD 20904							
31. Date filed (Month, Day, Year) JAN 28 2004				32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01948

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MELVIN L. DUKES</b>				2. Date of Death Month Day Year <b>JANUARY 24 2004</b>		3. Time of Death <b>5:15 A M</b>		
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death		
Funeral Director	5. Social Security Number <b>219 40 7367</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/1/43</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1174 E. NORTHERN PKWY.</b>				10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SKILL WORKER</b>		16b. Kind of Business/Industry <b>BALTO. CITY</b>				
	17. Father's Name (First, Middle, Last) <b>ERNEST DUKES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ZORA ELLERBE</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>ZORA E. MILES MOTHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1174 E. NORTHERN PKWY. BALTO. MD. 21239</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CEDAR HILL</b>		Date <b>1/29/04</b>		20c. Location - City or Town, State <b>BROOKLYN, MD.</b>		
	21. Signature of Funeral Service Licensee <b>C. A. ESTEP</b>				22. Name and Address of Facility <b>ESTEP BROS. FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>VENTRICULAR FIBRILLATION</b> Due to (or as a consequence of): b. <b>DILATED CARDIOMYOPATHY</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALCOHOL ABUSE</b>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dr. Gaitonde (M.D.)</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 24, 2004</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHILPA D. GAITONDE 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239</b>									
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature <b>Benita B. Spence</b>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01949

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Claire Elizabeth Dougherty

2. Date of Death  
Month Day Year

January 25 2004

3. Time of Death  
M

9:45 A.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Lorien Nursing and Rehab Center

4b. City, Town, or Location of Death

Mount Airy

4c. County of Death

Carroll

5. Social Security Number

214-30-4892

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

March 6, 1932

9. Birthplace (State or Foreign  
Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9852 Diversified Lane

10f. Zip Code

21042

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edgar T. Beach, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Rhoades

19a. Informant's Name/Relationship (Type, Print)

Edward W. Dougherty/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9852 Diversified Lane Ellicott City, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Crest Lawn Mem. Gar.

Date

01/29/2004

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensee

Peter S. [Signature]

22. Name and Address of Facility

Sterling Ashton Schwab Funeral Home, Inc.  
736 Edmondson Ave. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Congestive Heart Failure

b. Due to (or as a consequence of):

Atrial Fibrillation.

c. Due to (or as a consequence of):

Diabetes Mellitus

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetus death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
2 ☒ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 30641

29d. Date signed (Month, Day, Year)

January 26 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMESH SABAPATHI 201-109 Back River Neck Road Baltimore MD 21221

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 01950

## Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONNA DORSEY				2. Date of Death Month Day Year JANUARY 22nd 2004		3. Time of Death 11:23 P. M.	
	4a. Facility Name (If not institution, give street and number) North West Hospital				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-68-2842		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Apr 04 1957	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County NIA		10c. City, Town or Location Baltimore City	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 5029 Truesdale Avenue		10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Attendant		16b. Kind of Business/Industry Balto. Co. Schools			
	17. Father's Name (First, Middle, Last) William E. Griggs				18. Mother's Name (First, Middle, Maiden Surname) Margaret Duval			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) William E Griggs / Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5029 Truesdale Ave. Baltimore MD 21206			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet		20c. Location - City or Town, State Feb 2, 2004 Baltimore, MD		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Ronald A. Grayson				22. Name and Address of Facility Ronald P. Grayson Funeral Home 108 W. North Ave. Baltimore, MD 21201			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACQUIRED IMMUNE DEFICIENCY SYNDROME Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death							
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Ranganarayan MD		29c. License number DS4288		29d. Date signed (Month, Day, Year) January 22nd 2004			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ranganarayan Ranganarayan, Northwest Hospital Center, 5401 Old Court Rd MD 21133.							
	31. Date filed (Month, Day, Year) JAN 28 2004				32. Registrar's Signature Beverly B. Sparks			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01951

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Drumwright

2. Date of Death

JAN. 24

2004

11.45 P.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

BON SECURE HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

220-68-7427

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 8, 1938

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2542 W. PRATT STREET

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

0

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NEVER WORKED

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

UNK

18. Mother's Name (First, Middle, Maiden Surname)

MAE DRUMWRIGHT

19a. Informant's Name/Relationship (Type, Print)

JOANN MANNING (COUSIN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2202 W. LANVALE STREET BALTIMORE, MD 21216

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

1/31/04

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WYLIE FUNERAL HOME PA

638 N. GILMOR STREET BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

b. Hypotension

Due to (or as a consequence of):

c. SEPSIS

Due to (or as a consequence of):

d. GASTROINTESTINAL BLEEDING

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Terence J. Lamb M.D.

29c. License number

D37203

29d. Date signed (Month, Day, Year)

Jan. 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERENCE LAMB M.D. Bon Secours Hospital Baltimore, Md.

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01952

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANNIE P. DORSEY</b>				2. Date of Death Month <b>JANUARY</b> Day <b>23</b> Year <b>2004</b>				3. Time of Death <b>8:30PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CANTON FUTURE CARE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death	
Funeral Director	5. Social Security Number <b>218-26-6284</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>1-13-1933</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent				10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>1709 E. FAIRMONT AVE.</b>				10f. Zip Code <b>21231</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				15. Decedent's Education (Specify only highest grade completed) <b>10th</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSE ASSISTANT</b>				16b. Kind of Business/Industry <b>HEALTHCARE</b>				17. Father's Name (First, Middle, Last) <b>CARL PARSONS</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>NELLIE HAILEY</b>				19a. Informant's Name/Relationship (Type, Print) <b>ERNEST F. DORSEY / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1709 E. FAIRMONT AVE. BALTIMORE, MD 21231</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS CEMETERY</b>				20c. Location - City or Town, State <b>1-29-04 ARBUTUS, MARYLAND</b>	
	21. Signature of Funeral Service Licensee <b>Vaughn C. Greene</b>				22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL HOME</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute myocardial infarction</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Ischemic Heart Disease</b>				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred	
	28e. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>DR. VAUGHN C. GREENE</b>	
State Registrar	29c. License number <b>DO8358</b>				29d. Date signed (Month, Day, Year) <b>JAN 27 2004</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GRACIE K. PATRICK</b>	
	31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>				32. Registrar's Signature <b>DR. VAUGHN C. GREENE</b>				33. Date of Death <b>21231</b>	



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01953

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY VIRGINIA DETROW

2. Date of Death

January 22, 2004

3. Time of Death

8:30 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

WESLEY HOME

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-14-1146

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec 6, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2211 West Rogers Avenue

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Proprietor

16b. Kind of Business/Industry

Hair Salon/Beauty Care

17. Father's Name (First, Middle, Last)

Harry Samuel Detrow

18. Mother's Name (First, Middle, Maiden Surname)

Mary Josephine Mullen

19a. Informant's Name/Relationship (Type, Print)

Richard A. Lamond (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6409 Via Rosa, Boca Raton, Florida 33433-6471

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

1/26/2004

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Director

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RENAL FAILURE

Due to (or as a consequence of):

b. SEPTICEMIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ACUTE

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL INSUFFICIENCY;  
DEMENTIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert E. Roby, M.D.

29c. License number

D-19425

29d. Date signed (Month, Day, Year)

1/23/2004

30. Name and address of person who completed use of death (Item 23a) (Type, Print)

ROBERT E. ROBY, M.D. - 2211 W. ROGERS AVE - BALTIMORE, MD 21209

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

[Signature]

State  
RegistrarDETROW, MARY VIRGINIA  
EXPIRED 01-22-2004 @ 8 PM  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21268-0760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01954

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Savilla Mae (Bobbie) Dorsey

2. Date of Death

Month

Day

Year

January 21 2004

3. Time of Death

9:25pm

4e. Facility Name (If not institution, give street and number)

Stella Mavis Hospice at Mercy

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-18-2180

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

June 12, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1632 Milton Ave

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Washington C. Dorsey

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Spencer

19a. Informant's Name/Relationship (Type, Print)

Beatrice E. Kess

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7102 Talisman Ave Columbia Md. 21045

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arbutus Mem. PK.

Date

1/27/04

20c. Location - City or Town, State

Arbutus Md

21. Signature of Funeral Service Licensee

Blanca Adams Jones

22. Name and Address of Facility

MARSHALL W. JONES, JR. FUNERAL SVC PA  
1814 N. BROADWAY BALTO. MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

breast cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Phyllis

29c. License number

D408541

29d. Date signed (Month, Day, Year)

1/23/04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David Riseberg 301 ST PAUL PL Baltimore 21202

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

ORIGINAL

Dorsey, Savilla  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01955

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES DASCH</b>				2. Date of Death Month Day Year <b>Jan. 22, 2004</b>				3. Time of Death <b>10:55 p<sup>M</sup></b>	
	4a. Facility Name (If not institution, give street and number) <b>EASTPOINT REHAB &amp; NURSING CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>220-24-8813</b>		6. Sex <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MARCH 1, 1931</b>		9. Birthplace (State or Foreign Country)	
	Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>7007 E. BALTIMORE STREET</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1948-51</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) <b>8</b> Elementary/Secondary (0-12) <b>College (1-4or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PIPE INSULATOR</b>			16b. Kind of Business/Industry <b>BETHLEHEM STEEL</b>			
17. Father's Name (First, Middle, Last) <b>ANDREW DASCH</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET GAINER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>KENNETH SCHINDLER/FRIEND</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3430 YORKWAY, DUNDALK, MARYLAND 21222</b>					
20a. Method of Disposition <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OAK LAWN CEMETERY</b>			Date <b>1/27/04</b>		20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>LILLY &amp; ZEILER INC. FUNERAL HOME</b> <b>700 S. CONKLING STREET, BALTO., MD. 21224</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Atherosclerotic Heart Disease</b>										
23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23c. If yes, outcome of pregnancy <b>1</b> <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <b>4</b> <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9</b> <input type="checkbox"/> Unknown										
23d. Date of delivery Month Day Year										
Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. <b>Chronic obstructive Pulmonary Disease</b> <b>Cancer of the Prostate</b>										
23e. Did tobacco use contribute to the cause of death? <b>1</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <b>1</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No	
28d. Describe how injury occurred					28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number <b>211150</b>		29d. Date signed (Month, Day, Year) <b>01/23/2004</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224</b>										
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>					32. Registrar's Signature 					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01956

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Abraham Eagle

2. Date of Death  
Month Day Year

01 22 2004

3. Time of Death  
0121 M

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

072-22-3700

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
Month Day Year

APR. 22 1928

9. Birthplace (State or Foreign  
Country)

NY

Usual Residence of Decedent

10a. State  
MD10b. County  
BALTIMORE10c. City, Town or Location  
CATONSVILLE10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

1324 HICKORY SPRINGS CIRCLE

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: WHITE15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CHEMIST

16b. Kind of Business/Industry

CHEMISTRY

17. Father's Name (First, Middle, Last)

AARON HARRY

EAGLE

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

LEVINSON

19a. Informant's Name/Relationship (Type, Print)

MRS. TOBIANNE EAGLE/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1324 HICKORY SPRINGS CIRCLE CATONSVILLE, MD. 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
Institution, Mortuary, or place)

WOODMOOR HEBREW CONG. JAN. 25, 2004 BALTIMORE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.  
8900 REISTERSTOWN ROAD PIKESVILLE, MD. 2120823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Ventricular tachycardia

Approximate  
Interval Between  
Onset and Death

5 minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

Ischemic cardiomyopathy

b. Due to (or as a consequence of):

Coronary artery disease

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

10 years

15 years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure

Chronic obstructive pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D20604 Maryland

29d. Date signed (Month, Day, Year)

1/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard A. Berg, MD

#450, 10155 Falls Rd, Lutherville, Md 21093

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01957

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wesley Cleveland Evans

2. Date of Death

January 23 2004

3. Time of Death  
7:45 A.M. M

4a. Facility Name (If not institution, give street and number)

4901 Lasalle Ave

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212 46 0612

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 10, 1948

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4901 Lasalle Ave

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Corrected Officer

16b. Kind of Business/Industry

CORRECTIONS

17. Father's Name (First, Middle, Last)

VIRGIN EVANS

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Bennett

19a. Informant's Name/Relationship (Type, Print)

Richardson Easterwood

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

YOWEN COURT, Baltimore, MD

21236

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cemetery

Date

1/27/04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

James Beets

22. Name and Address of Facility

BHS Funeral Home  
1129 N. CAROLINE ST BALTIMORE MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
13 mon

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death  
☐ Pregnant at time of death  
☐ Unknown

3. Ectopic pregnancy

5. Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Charles Padgett

29c. License number

D15546

29d. Date signed (Month, Day, Year)

Jan 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Padgett, MD, 5601 Loch Raven Blvd, Baltimore, MD 21239

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68769

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01958

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>John Ferguson</i>		2. Date of Death Month <i>January</i> Day <i>25</i> Year <i>2004</i>		3. Time of Death <i>11:06 PM</i>
	4a. Facility Name (If not institution, give street and number) <i>The Johns Hopkins Hospital</i>		4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death <i>N/A</i>
Funeral Director	5. Social Security Number <i>224-26-5214</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>80</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>Sept. 17, 1923</i>	9. Birthplace (State or Foreign Country) <i>V.A.</i>
	Usual Residence of Decedent				
10a. State <i>M.D.</i>		10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <i>1517 N. Spring Street</i>			10f. Zip Code <i>21213</i>	10g. Citizen of What Country? <i>U.S.A.</i>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Truck Driver</i>	
16b. Kind of Business/Industry <i>Baltimore City</i>		17. Father's Name (First, Middle, Last) <i>James G. Ferguson</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Mattie Stokes</i>	
19a. Informant's Name/Relationship (Type, Print) <i>Rosa Ferguson- Wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1517 N. Spring St. Balto., M.D. 21213</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Memorial Park</i>		20c. Location - City or Town, State <i>1/30/2004 Balto., M.D.</i>	
21. Signature of Funeral Service Licensee <i>Herbert Nutter</i>		22. Name and Address of Facility <i>Nutter Funeral Home Inc. 2501 Gwynnsfalls Pkwy Balto., M.D. 21216</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <i>Ventricular Fibrillation</i>			Approximate Interval Between Onset and Death <i>5 minutes</i>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <i>Pneumonia</i>			<i>One week</i>
		c. <i>Emphysema</i>			<i>10 years</i>
		d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Sara Tolaney, MD</i>		29c. License number <i>RES-000</i>		29d. Date signed (Month, Day, Year) <i>January 27, 2004</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Sara Tolaney Johns Hopkins, Tower 110, 600 North Wolfe Street, Baltimore, MD 21287</i>					
31. Date filed (Month, Day, Year) <i>JAN 28 2004</i>		32. Registrar's Signature <i>Barbara B. Baker</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01959

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Owen W. Froeming				2. Date of Death Month Day Year Jan. 25, 2004		3. Time of Death 3:30 A M	
	4a. Facility Name (If not institution, give street and number) 16 N. Bell Grove Road				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-30-8046		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 23, 1933	
	9. Birthplace (State or Foreign Country) Washington		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 16 N. Bell Grove Road		10f. Zip Code 21228		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Art Director		16b. Kind of Business/Industry Manufacturing			
	17. Father's Name (First, Middle, Last) Emil J. Froeming				18. Mother's Name (First, Middle, Maiden Surname) Bess Owens			
	19a. Informant's Name/Relationship (Type, Print) JoAnn L. Froeming / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 N. Bell Grove Road, Catonsville, Md. 21228			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 1/27/04		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Prostate Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 1/2 yrs							
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Paul Gormley MD 29c. License number D18587 29d. Date signed (Month, Day, Year) JAN 27 2004								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL GORMLEY 900 CATON AVE BALTIMORE MD 21229								
31. Date filed (Month, Day, Year) JAN 28 2004				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10+

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01960

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Gladys C. Flandorfer				2. Date of Death Month Day Year January 26, 2004		3. Time of Death 0738AM	
4a. Facility Name (If not institution, give street and number) St. Agnes Healthcare				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
5. Social Security Number 217-12-7167		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 1, 1914	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 910 Prestwood Road				10f. Zip Code 21228		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Roy C. Keeney				18. Mother's Name (First, Middle, Maiden Surname) Cora Beck			
19a. Informant's Name/Relationship (Type, Print) Kelly L. Ewing - Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1012 Irwins Choice, Belair, Maryland 21014			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 1/29/04		20c. Location - City or Town, State Woodlawn, Maryland	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkins Avenue, Baltimore, Maryland 21229			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute myocardial infarction</i> Due to (or as a consequence of): b. <i>Arrhythmia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>unknown</i> <i>unknown</i>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Bichhuong M. Dinh, MD				29c. License number 754996		29d. Date signed (Month, Day, Year) January 26, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bichhuong M. Dinh 900 S. Caton Avenue, Baltimore, MD							
31. Date filed (Month, Day, Year) JAN 28 2004				32. Registrar's Signature <i>[Signature]</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01961

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James

Acory

Fincham

2. Date of Death

Month

Day

Year

JANUARY 19 2004 5:45 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

Cecil

5. Social Security Number

229-44-9709

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 14, 1930

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

VA

10b. County

Warren

10c. City, Town or Location

Front Royal

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

376 W. 11th Street

10f. Zip Code

22630

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 8/3/48 to 5/19/52

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary (Secondary 0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Painting Company

17. Father's Name (First, Middle, Last)

James Fincham

18. Mother's Name (First, Middle, Maiden Surname)

Emily Jenkins

19a. Informant's Name/Relationship (Type, Print)

Brenda Chrisman (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

35 Westminister Dr. Front Royal, VA 22630

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Culpeper Nat'l Cem.

Date

1-23-04

20c. Location - City or Town, State

Culpeper, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Maddox Funeral Home

105 W. Main St. Front Royal, Virginia

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status Post Coronary Artery Bypass Graft  
Status Post Aortic Valve Replacement  
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was decedent referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

29e. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29f. Date filed (Month, Day, Year)

32. Registrar's Signature

32. Registrar's Signature

32. Registrar's Signature

32. Registrar's Signature

32. Registrar's Signature

32. Registrar's Signature

State  
Registrar

JAN 28 2004

ORIGINAL

NAME KNOWN TO PHYSICIAN:  
FINCHAM, JAMES A  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01962

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margueritta A. FISCHER				2. Date of Death Month Day Year January 26 2004		3. Time of Death 1:12 pm
	4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE AT MERCY				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 216-28-2784	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 23 1931	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State Md.		10b. County St. Mary's County		10c. City, Town or Location Hollywood		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 24550 Clarks Landing Lane				10f. Zip Code 20636		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner		16b. Kind of Business/Industry Tavern	
17. Father's Name (First, Middle, Last) Aubrey Clarke				18. Mother's Name (First, Middle, Maiden Surname) Agnes Capsey			
19a. Informant's Name/Relationship (Type, Print) Jacqueline Pindell (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11555 Monument Lake Circle, Jacksonville Fla. 32225			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 01/28/2004		20c. Location - City or Town, State Baltimore, Md.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Cervical cancer</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) hospice					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D408541		29d. Date signed (Month, Day, Year) 1/26/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Riseberg 301 St Paul Pl. Baltimore 21202							
31. Date filed (Month, Day, Year) JAN 28 2004				32. Registrar's Signature 			

Fischer, Margueritta  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21268-0760

15



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01963

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vincent Ambrose Ferrari

2. Date of Death

Month Day Year  
January 19, 2004

3. Time of Death

8:22 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

213-32-4987

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 23, 1935

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7629 A Spencer Road

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Liquor Distributor

17. Father's Name (First, Middle, Last)

Joseph Ferrare

18. Mother's Name (First, Middle, Maiden Surname)

Maria Fritch

19a. Informant's Name/Relationship (Type, Print)

Mrs. Lisa Urban / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 Ridge View Drive Westminster, MD 21157

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Cremation

Date

Jan 25  
2004

20c. Location - City or Town, State

Stevensville, MD

21. Signature of Funeral Service Licensee

Donatella M01364

22. Name and Address of Facility Singleton Funeral Home, P.A.

1 Second Avenue SW Glen Burnie, MD 21061

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?☐ Yes ☐ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an  
autopsy  
performed?  
☒ Yes ☐ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
☒ Yes ☐ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Ling Li, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LING LI, M.D.

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Benjamin B. Spence

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01966

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Helen Louise Foy		2. Date of Death Month Day Year January 27 2004		3. Time of Death 04:00P <sup>M</sup>	
4a. Facility Name (If not institution, give street and number) 7751 Ricker Road		4b. City, Town, or Location of Death Severn		4c. County of Death Anne Arundel	
5. Social Security Number 220-74-9368	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	8. Date of Birth (Month, Day, Year) May 3 1909	9. Birthplace (State or Foreign Country) MD	
Usual Residence of Decedent					
10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Severn		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 7751 Ricker Road		10f. Zip Code 21144		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Joseph Sczerbicki			18. Mother's Name (First, Middle, Maiden Surname) Michaelina Klas		
19a. Informant's Name/Relationship (Type, Print) Mr. Carl Foy / Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7747 Ricker Road Severn, MD 21144		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		20c. Location - City or Town, State Jan 30 2004 Glen Burnie, MD	
21. Signature of Medical Service Licensee 		22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue Glen Burnie, MD 21061			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dilated Cardiomyopathy b. Pericarditis c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 047137		29d. Date signed (Month, Day, Year) January, 28, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER NAMIKER MD 7845 Oakwood Rd Suite 201, Glen Burnie Md 21061					
31. Date filed (Month, Day, Year) JAN 28 2004		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01965

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SHIRLEY CHARLOHE FERGUSON

2. Date of Death

January 23, 2004

3. Time of Death

3:45

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

219-01-8559

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs., last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-30-19

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1001 SHELL BANKS ROAD

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

FOOD

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

HARRIET MIDDLETON / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3933 KEXMORE ROAD BALTIMORE, MD 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

1-30-04 PIKESVILLE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Vanya Grace

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL HOME  
4905 YORK ROAD BALTIMORE, MARYLAND 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D410854

29d. Date signed (Month, Day, Year)

1/22/2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David, Riseberg 301 ST PAUL PL. Baltimore 21202

31. Date filed (Month, Day, Year)

JAN 28 2004

Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01966

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>HATTIE L. FOWLER</i>				2. Date of Death Month <i>JANUARY</i> Day <i>19</i> Year <i>2004</i>		3. Time of Death <i>5:45 A M</i>	
	4a. Facility Name (If not institution, give street and number) <i>HARBOR HOSPITAL CENTER</i>				4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>BALTIMORE CITY</i>	
Funeral Director	5. Social Security Number <i>214 50 3344</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>55</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>FEB. 9, 1948</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>Maryland</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Baltimore</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>	
	17. Father's Name (First, Middle, Last) <i>Oscar Stennett Sr.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Silvia Horseman</i>			
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) <i>Katherine Lanarehr / Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>22 Cedar Hill Road Baltimore, Maryland 21225</i>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Bayview Crematory</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>		20d. Date <i>1/21/2004</i>	
To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee <i>Sharon Riggall</i>				22. Name and Address of Facility <i>George J. Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>PNEUMONIA</i>				Approximate Interval Between Onset and Death <i>2 days</i>			
To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) <i>SEPSIS</i>				Due to (or as a consequence of): <i>2 days</i>			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Due to (or as a consequence of):			
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i> <i>Diabetes mellitus</i> <i>Renal Failure</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>MD. First Year Intern</i>			
To Be Completed by Physician/Medical Examiner	29c. License number <i>P-17785</i>				29d. Date signed (Month, Day, Year) <i>JANUARY, 19, 2004</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>HARIS ALI 3001 S. HANOVER ST, BALTIMORE, MD - 21225</i>				31. Date filed (Month, Day, Year) <i>JAN 28 2004</i>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>[Signature]</i>				33. State Registrar <i>[Signature]</i>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #4a per me G823 2/19/04 tas  
Certificate of Death

Reg. No.

2004 01967

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary L. Gorwell				2. Date of Death Month Year JANUARY 20, 2004				3. Time of Death 2:20 P M						
	4a. Facility Name (If not institution, give street and number) <del>Union Memorial Hospital</del> GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death						
Funeral Director	5. Social Security Number 218-14-0275		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) Apr 9, 1910		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent				10f. Zip Code 21218		10g. Citizen of What Country? United States		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore											
10e. Street and Number 522 E. 35th Street				10f. Zip Code 21218				10g. Citizen of What Country? United States							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Candy Sales				16b. Kind of Business/Industry Retail							
17. Father's Name (First, Middle, Last) Edward Louis Treulieb				18. Mother's Name (First, Middle, Maiden Surname) Susan Lee Marshall											
19a. Informant's Name/Relationship (Type, Print) Mr. Vernon Gorwell/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 E. 35th Street, Baltimore, MD 21218											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory				Date Jan 26 2003		20c. Location - City or Town, State Beltsville, MD					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown				3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number O C M E		29d. Date signed (Month, Day, Year) JANUARY 21, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenberg M.D.										111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JAN 28 2004				32. Registrar's Signature 											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01968

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Grimm

2. Date of Death

Jan. 25, 2004

3. Time of Death

10:20 p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

1 Bristol Hill Court, A-1

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-18-4574

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 4, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 Bristol Hill Court, A-1

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Police

16b. Kind of Business/Industry

Dept. of Transportation

17. Father's Name (First, Middle, Last)

George H. Grimm

18. Mother's Name (First, Middle, Maiden Surname)

Clara Griffin

19a. Informant's Name/Relationship (Type, Print)

Gloria M. Grimm / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Bristol Hill Ct., A-1, Catonsville, Md. 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Meadowridge Mem. Pk.

Date

1/31/04

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hubbard Funeral Home, Inc.  
4107 Wilkens Ave. Baltimore, Maryland 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC COLON CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 mos.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29. Certifier  
(Check only  
one)2. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D0019419

29d. Date signed (Month, Day, Year)

JANUARY 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DIANA H. GRIFFITHS 900 CATON AVE. BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 1- Amend Items 10f, 12, 19b per FH, G828, 02/11/04 dhh  
 Reg. No. 2004 01969

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harley Goble, Jr.</b>		2. Date of Death Month <b>January</b> Day <b>22</b> Year <b>2004</b>		3. Time of Death <b>1:05 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Casey House</b>		4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>246-22-0604</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Dec. 11, 1925</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>15066 Haslemere Ct.</b>		10f. Zip Code <b>20855 20906</b>		10g. Citizen of What Country? <b>U.S.A.</b>
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-46 1941 1948-1952 1952</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Owner</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner</b>		16b. Kind of Business/Industry <b>Restaurant</b>
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Harley R. Goble, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Broyhill</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>FRANCES M. GOBLE (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15066 Haslemere Ct., Silver Spring, MD 20855 20906</b>		
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Stony Point Cemetery</b>		20c. Location - City or Town, State <b>1/24/2004 Stony Point, NC</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Chapman Funeral Home Rt. 2 Box 140 Stony Point, NC 28678</b>		
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Chronic Renal Insufficiency</b>				Approximate Interval Between Onset and Death <b>Years</b>
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>S/P Cancer of Larynx Hypertension</b>				23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		24c. Date of delivery Month <b>January</b> Day <b>22</b> Year <b>2004</b>
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>		
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D09470</b>
	29d. Date signed (Month, Day, Year) <b>January 22, 2004</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Eugene P. Libre, M.D. 10400 Connecticut Ave., Kensington, MD</b>		
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature 		
	33. Registrar's Signature 				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68768

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01970

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Roger Lee Gordon Sr.			2. Date of Death Month Day Year JAN. 22, 2004		3. Time of Death 1925 PM	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL			4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 218-44-0230	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept, 03 1942	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Pasadena		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 8371 Penn Drive		10f. Zip Code 21122		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tree Trimmer		16b. Kind of Business/Industry Asplundh Tree Co.		
	17. Father's Name (First, Middle, Last) Michael Henry Gordon			18. Mother's Name (First, Middle, Maiden Surname) Eleanor Cunningham			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Roger L. Gordon, Jr. (son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8116 Main Creek Road, Pasadena, MD 21122			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date Jan. 28 2004		20c. Location - City or Town, State Baltimore, Maryland
	21. Signature of Funeral Service Licensee			22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head and Chest Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 1/22/04		28b. Time of Injury 7 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Road		28d. Describe how injury occurred Pedestrian struck by motor vehicle 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pasadena, MD			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Ling Li M.D.				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JAN. 23, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI, M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) JAN 28 2004				32. Registrar's Signature L. Sparks			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68750

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be secured within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01971

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD JOHN GUINN

2. Date of Death

Month Day Year  
JANUARY 28, 2004

3. Time of Death

6:45 A M

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF GLEN BURNIE

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral Director

5. Social Security Number

212-36-6241

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

OCT. 19, 1937

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7959 TELEGRAPH ROAD

10f. Zip Code

21144

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

AUTO MECHANIC

16b. Kind of Business/Industry

AUTO REPAIR

17. Father's Name (First, Middle, Last)

BENJAMIN GUINN

18. Mother's Name (First, Middle, Maiden Surname)

ISABEL HARRIS

19a. Informant's Name/Relationship (Type, Print)

TIMOTHY R. GUINN - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7959 TELEGRAPH ROAD SEVERN, MARYLAND 21144

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date  
JANUARY 29 2004

20c. Location - City or Town, State

CATONSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

KIMBLE-ARNDT FUNERAL HOME P.A. 21061

421 CRAIN HIGHWAY S.E. GLEN BURNIE, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
☐ Yes ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

D17753

29d. Date signed (Month, Day, Year)

1/28/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. S. DHARMASENA, MD. 710 CHURCH ST. BALTIMORE, MD 21225

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

State Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01972

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Robert

Gwin

2. Date of Death  
Month Day Year

January 23, 2004

3. Time of Death

01:40 A M

4a. Facility Name (If not institution, give street and number)

Crofton Convalescent Center

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

5. Social Security Number

216-68-7839

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Jun 14, 1954

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8473 New Cut Road

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Fibers

17. Father's Name (First, Middle, Last)

Claude Gwin

18. Mother's Name (First, Middle, Maiden Surname)

Maria Pizzolitto

19a. Informant's Name/Relationship (Type, Print)

Mrs. Linda Trimper / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3277 Old Taneytown Road Westminster, MD 21158

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Cremation

Date

Jan 27  
2004

20c. Location - City or Town, State

Stevensville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Singleton Funeral Home, P.A.

1 Second Avenue SW Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Recurrent Aspiration Pneumonia

Approximate  
Interval Between  
Onset and Death

Weeks

Due to (or as a consequence of):

b. Quadripare sis

19 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Global Aphasia.

Dysphagia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Rakesh Arora MD

29c. License number

D20108

29d. Date signed (Month, Day, Year)

1/27/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Rakesh Arora 14300 Gallant Fox Lane Suite 221 Bowie, MD 20715

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01973

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Emma G. Gott

2. Date of Death

Jan 17, 2004

3. Time of Death

2:41 Pm. M

4a. Facility Name (If not institution, give street and number)

Manor Care (Falls Road)

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212-20-9918

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec 24, 1919

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8114 Gray Stone Lane

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Hair Care

17. Father's Name (First, Middle, Last)

Ernest Green

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Green

19a. Informant's Name/Relationship (Type, Print)

Desney Byrd

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8114 Gray Stone Lane Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Date

01/23/04

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

*Eul 4 Step*

22. Name and Address of Facility

Estep Brothers Funeral Home P.A.  
1300 Eutaw Place Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. *metastatic Breast Cancer*  
Due to (or as a consequence of):  
b. *Right Frontal haemorrhage (old)*  
Due to (or as a consequence of):  
c. *Pneumonia*  
Due to (or as a consequence of):  
d. *Degenerative Joint Disease*

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown

3 ☐ Ectopic pregnancy

5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Diarrhea*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No X

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Dr. [Signature]* MD

29c. License number

D 31464

29d. Date signed (Month, Day, Year)

1/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARIS A. HASHEMI, 821 N. Eutaw St Suite 308 Balt. MD 21201

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

*[Signature]*

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01975

1- For State Registrar

Physician / Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>MARTIN G. GOETZ</b>		2. Date of Death Month Day Year <b>JANUARY 22, 2004</b>		3. Time of Death <b>11:25 A.M.</b>
4a. Facility Name (If not institution, give street and number) <b>GILCHRIST CENTER</b>		4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>
5. Social Security Number <b>717-12-5045</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>9/12/1919</b>	
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>				
Usual Residence of Decedent				
10a. State <b>MD</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>GLEN ARM</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number <b>11701 MANOR ROAD</b>		10f. Zip Code <b>21057</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH GRADE</b> College (1-4 or 5+) <b>COLLEGE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CARPENTER</b>		16b. Kind of Business/Industry <b>UNION</b>
17. Father's Name (First, Middle, Last) <b>JOHN H. GOETZ</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARY C. HYLAND</b>		
19a. Informant's Name/Relationship (Type, Print) <b>SHARON GOETZ / DAUGHTER-IN-LAW</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16501 J.M. PEARCE ROAD MONKTON, MD 21111</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. JOHN'S CEMETERY</b>		20c. Location - City or Town, State <b>HYDES, MD</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Lung Cancer</b>				Approximate Interval Between Onset and Death <b>month</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Stroke</b> <b>Atrial fibrillation</b>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number <b>D25205</b>		29d. Date signed (Month, Day, Year) <b>January 22, 2005</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A. Riley GPMC 6701 N. Charles St. Balto Md 21204</b>				
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For Amend Item 17 per State Registrar  
 State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death  
 Reg. No. 2004 01976

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Isaac Goodwin</b>				2. Date of Death Month <b>JANUARY</b> Day <b>19</b> Year <b>2004</b>		3. Time of Death <b>10:55 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>071-26-1340</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>6/27/26</b>	9. Birthplace (State or Foreign Country) <b>South Carolina</b>			
	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County	10c. City, Town or Location <b>Baltimore</b>		10e. Street and Number <b>722 E. 33<sup>RD</sup> Street</b>			
	10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary <b>9<sup>th</sup></b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Manager Apt. Building</b>		16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) <b>Isaac Goodwin Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ann Major</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Annie E. Goodwin (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>722 E. 33<sup>RD</sup> St. Balto. MD 21213</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshells Cemetery</b>		20c. Location - City or Town, State <b>Balto. MD.</b>		20d. Date <b>1/24/04</b>	
	21. Signature of Funeral Service Licensee <b>Erin W. Linn</b>		22. Name and Address of Family <b>Vaughan C. Greene Funeral Services 4405 York Rd. Balto MD 21212</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Non Small cell lung cancer</b>		23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23c. Date of delivery Month Day Year		Approximate Interval Between Onset and Death <b>3 years</b>	
	23d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Lavanya Yarbogadda MD</b>		29c. License number <b>D 59027</b>		
29d. Date signed (Month, Day, Year) <b>1/20/04</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lavanya Yarbogadda MD, Union Memorial Hospital, Baltimore, MD 21218</b>		31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature <b>[Signature]</b>		

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 01977

1- For State Registrar

Physician / Medical Examiner  
Funeral Director

1. Decedent's Name (First, Middle, Last) <b>RUDOLPH J. GILLIS JR.</b>		2. Date of Death Month <b>January</b> Day <b>21</b> Year <b>2004</b>		3. Time of Death <b>7:30 PM</b>
4a. Facility Name (If not institution, give street and number) <b>St. Agnes Health care</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
5. Social Security Number <b>217-24-3396</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>10-25-1931</b>	9. Birthplace (State or Foreign Country) <b>NORTH CAROLINA</b>

Usual Residence of Decedent		10a. State <b>MD</b>		10b. County	10c. City, Town or Location <b>BALTIMORE</b>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>2706 BERYL AVE.</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FOREMAN</b>	16b. Kind of Business/Industry <b>STEEL</b>
---	--	---	--

17. Father's Name (First, Middle, Last) <b>RUDOLPH J. GILLIS SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LENA BROWN</b>	
19a. Informant's Name/Relationship (Type, Print) <b>PHYLIS GILLIS</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2706 BERYL AVE. BALTIMORE, MD 21205</b>	

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS CEMETERY</b>	Date <b>1-29-04</b>	20c. Location - City or Town, State <b>ARBUTUS, MARYLAND</b>
21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL HSE. 4905 YORK ROAD BALTIMORE, MD 21212</b>		

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Prostate Cancer</b> Due to (or as a consequence of): <b>b. Chronic Kidney Disease</b> Due to (or as a consequence of): <b>c. Hypertension</b> Due to (or as a consequence of): <b>d. Anemia</b>		Approximate Interval Between Onset and Death <b>years</b> <b>years</b> <b>years</b>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown
23d. Date of delivery Month Day Year		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>S. YOUSIF, M.D.</b>	29c. License number <b>D0060501</b>	29d. Date signed (Month, Day, Year) <b>January 21, 2004</b>
--	--	---	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SOHAIR YOUSIF 900 Caton Ave Baltimore, MD 21229</b>	
--	--

31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>	32. Registrar's Signature <b>[Signature]</b>
---	---

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 2024.

Physician / Medical Examiner  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01978

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

Mary Richardson Garner

2. Date of Death

January 20 2004

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

Levindale Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

220-20-0311

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month/Day/Year)

12/24/25 Maryland

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

702 Saint Dunstons Rd

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)

School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Charles Richardson

18. Mother's Name (First, Middle, Maiden Surname)

Julia Perkins

19a. Informant's Name/Relationship (Type, Print)

Michael Garner (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5517 Vinings Lakeshore, Mableton GA 30126

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cemetery

Date

1/27/04

20c. Location - City or Town, State

Balto. MD

21. Signature of Funeral Service Licensee

Sam W. Smith

22. Name and Address of Facility

Cremation Services

5151 Balto. National Pike, Balto. MD. 21229

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE RENAL DISEASE

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No

3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death

5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DDA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Debra S. Wertheimer MD

29c. License number

D23767

29d. Date signed (Month, Day, Year)

January 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debra S. Wertheimer MD, 2434 W. Belvedere Ave, Balto, MD 21215

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Debra S. Wertheimer

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be examined within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01979

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Daniel Green</b>		2. Date of Death Month <b>January</b> Day <b>24</b> Year <b>2004</b>		3. Time of Death <b>1515 M</b>
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>218-48-4282</b>	6. Sex <b>MALE</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>June 11, 1946</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>
	10c. City, Town or Location <b>Dundalk</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3425 McShane Way</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>12 Years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steelworker</b>
	16b. Kind of Business/Industry <b>Steel Industry</b>		17. Father's Name (First, Middle, Last) <b>Frederick E. Green</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Vera J. Golia</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Mildred M. Green (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3425 McShane Way Dundalk, Maryland 21222</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		20c. Location - City or Town, State <b>1/29/2004 Rosedale, Maryland</b>
	21. Signature - Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Stroke</b> Due to (or as a consequence of): <b>b. Brain tumor</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier <b>[Signature]</b> 29c. License number <b>RES 000</b> 29d. Date signed (Month, Day, Year) <b>1/26/04</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Hoan Tran MD 4940 Eastern Avenue, Baltimore, MD 21224</b>					
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b> 32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01980

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STANLEY</b>		2. Date of Death Month <b>January</b> Day <b>22</b> Year <b>2004</b>		3. Time of Death <b>2300 M</b>
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>220-07-0726</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	8. Date of Birth Month <b>Jan</b> Day <b>26</b> Year <b>1922</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>6534 COPPERFIELD ROAD</b>		10f. Zip Code <b>21209</b>	10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>6</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DEALER</b>		16b. Kind of Business/Industry <b>ART</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>EDWARD</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LENA BERMAN</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>MRS. IRMA GAMSON/WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6534 COPPERFIELD ROAD BALTIMORE, MD. 21209</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of Facility, City or Town, State) <b>PETACH TIKVAH CONG</b>		20c. Location - City or Town, State <b>ROSEDALE, MD.</b>
	21. Signature of Funeral Service Licensee <b>Edward C. Reed</b>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebral</b> <b>b. Myelodysplastic Syndrome</b> <b>c.</b> <b>d.</b> Approximate Interval Between Onset and Death <b>20 days</b> <b>4 years</b>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Laura B. Hupel</b>		29c. License number <b>060979</b>		29d. Date signed (Month, Day, Year) <b>1/22/04</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type/Print) <b>Laura B. Hupel Johns Hopkins Hospital 600 N. Wolfe St. Baltimore MD</b>					
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01981

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Angela Lorraine Heavens

2. Date of Death  
Month Day Year

January 23, 2004

3. Time of Death

1:29 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

352-50-1189

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

July 27, 1956

9. Birthplace (State or Foreign  
Country)

St. Louis, MO

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15623 Plaid Drive

10f. Zip Code

20707

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Social Worker

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Joseph Heavens

18. Mother's Name (First, Middle, Maiden Surname)

Annie Muskin

19a. Informant's Name/Relationship (Type, Print)

Patricia Heavens-Kosh -

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

126 Glen Cove Dr., Chesterfield, MO 63017

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sunset Garden of Memory 1/31/04

Date

20c. Location - City or Town, State

Milstadt, IL

21. Signature of Funeral Service Licensee

Dennis Pittman

22. Name and Address of Facility

Wade Funeral Home  
4828 Natural Bridge Blvd., St. Louis, MO 6311523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Pulmonary Compromise

a. Due to (or as a consequence of):

Ovarian Cancer

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Paul Mackaul

29c. License number

47612

29d. Date signed (Month, Day, Year)

1/23/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Mackaul, M.D.

1500 Forest Glen Road., Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Benjamin B. Spates

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68788,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01992

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BETTY LEE HAUSE</b>		2. Date of Death Month Day Year <b>JANUARY 21 2004</b>		3. Time of Death <b>10:20 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>n/a</b>
Funeral Director	5. Social Security Number <b>214-26-7477</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Oct. 25 1928</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Md.</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number <b>1526 S. Hanover Street</b>		10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Webster Clothes</b>	
17. Father's Name (First, Middle, Last) <b>Samuel Hunt</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Tragesser</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Gloria Carper (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1739 Clarkson Street, Baltimore, Md. 21230</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A. 130 E. Fort ave. Baltimore, Md. 21230</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ACUTE RENAL FAILURE</b>		Due to (or as a consequence of): <b>SCLERODERMA</b>		Approximate Interval Between Onset and Death <b>1 month</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>THROMBOCYTOPENIA</b>		Due to (or as a consequence of):		<b>2 weeks</b>	
<b>HEMOLYTIC ANEMIA</b>		Due to (or as a consequence of):		<b>2 weeks</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23a. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  <b>Medical Doctor</b>		29c. License number <b>P-17785</b>		29d. Date signed (Month, Day, Year) <b>JANUARY, 23, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HARIS ALI 3001 S. HANOVER ST, BALTIMORE, MD - 21225</b>					
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01983

1- For State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ELSIE Mae HALDEMAN</b>		2. Date of Death Month <b>JANUARY</b> Day <b>23</b> Year <b>2004</b>		3. Time of Death <b>1:30 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>Baltimore City</b>	
5. Social Security Number <b>185-09-4439</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>98</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>6-5-1905</b>		9. Birthplace (State or Foreign Country) <b>PA</b>
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Millersville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1004 Oakdale Cir.</b>		10f. Zip Code <b>21108</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home maker</b>	
16b. Kind of Business/Industry <b>Home owner</b>		17. Father's Name (First, Middle, Last) <b>Joseph W. Thomas</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hannah Greene Thomas</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Louise Houck / daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1004 Oakdale Cir. Millersville MD 21108</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mathews Cemetery</b>		20c. Location - City or Town, State <b>1/28/2004 Chester Springs, PA</b>	
21. Signature of Funeral Service Licensee <b>Diana M. Salas</b>		22. Name and Address of Facility <b>Singleton Funeral Home 1 Second Ave SW Glen Burnie MD 21061</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b> Due to (or as a consequence of): <b>PNEUMONIA</b> Due to (or as a consequence of): <b>CHRONIC RENAL FAILURE.</b>		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>M. Shah, MD PGY-2</b>		29c. License number <b>P-16775</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 23, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NIRISH SHAH, MD 3001 S. HANOVER ST. BALTIMORE, MD-21225</b>					
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 01981

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter P Heard		2. Date of Death Month Day Year January 24 2004		3. Time of Death 8:10 AM
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 216 44 7770	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	8. Date of Birth (Month, Day, Year) 11/15/1948	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County NA	10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 2301 PENTLAND DRIVE		10f. Zip Code 21234		10g. Citizen of What Country? USA
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TECHNICIAN		16b. Kind of Business/Industry BENDIX ELECTRICAL		
	17. Father's Name (First, Middle, Last) JOHN DAVIS HEARD		18. Mother's Name (First, Middle, Maiden Surname) ANNIE RUTH HOLLWAY		
	19a. Informant's Name/Relationship (Type, Print) TARA R. HEARD (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3318 E. NORTHERN PKWY BALTIMORE, MD 21206		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK		20c. Location - City or Town, State 1/31/04 RANDALLSTOWN, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Septic Arthritis. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ankylosing Spondylitis.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 					
29c. License number RES-000					
29d. Date signed (Month, Day, Year) Jan. 24. 04					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khaled Hassan 5601 Loch Raven Blvd. Baltimore, MD 21239					
31. Date filed (Month, Day, Year) JAN 28 2004					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01985

1- For State Registrar

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last)

Beatrice E. Harris

2. Date of Death

Month 01 Day 24 Year 2004

3. Time of Death

6.25 PM

Funeral Director

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

237 52 6722

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) August 28, 1929

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3529 Kentucky Ave

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4yr 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Adm

16b. Kind of Business/Industry

School System

17. Father's Name (First, Middle, Last)

Jeddie Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Essie Lee

19a. Informant's Name/Relationship (Type, Print)

Rosa Crenshaw

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3529 Kentucky Ave Baltimore MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

1/29/04

20c. Location - City or Town, State

Woodlawn MD

21. Signature of Funeral Service Licensee

Patricia Best

22. Name and Address of Facility

Betts Funeral Home  
1129 N. Caroline St Baltimore MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage Renal Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pancytopenia  
Gastrointestinal Bleed.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Pinelis M.D.

29c. License number

P 16914

29d. Date signed (Month, Day, Year)

Jan. 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dmitry Pinelis 5601 Loch Raven Boulevard, Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Benjamin B. Spahr

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01986

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel R. Harvey

2. Date of Death

Jan. 25, 2004

3. Time of Death

6:35 a.m.

4a. Facility Name (If not institution, give street and number)

Charlestown Retirement Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

219-38-9554

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Dec. 18, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

White Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2417 Garrett Rd.

10f. Zip Code

21161

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Frederick O. Seyter

18. Mother's Name (First, Middle, Maiden Surname)

Florence L. Eppers

19a. Informant's Name/Relationship (Type, Print)

Joan R. Warnsmann - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2417 Garrett Rd., White Hall, Md. 21161

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Mem. Park

Date

Jan. 29, 2004

20c. Location - City or Town, State

Sykesville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Eckhardt Funeral Chapel, P.A.

21117

11605 Reisterstown Rd., Owings Mills, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Weeks

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atherosclerotic coronary artery disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

003989

29d. Date signed (Month, Day, Year)

January 25 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myla M. Carpenter, MD 711 Maiden Choice Ln Catonsville MD

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01987

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Elmer C. Jones Sr.		2. Date of Death Month Day Year January 23 2004		3. Time of Death 5:15 A <sup>M</sup>	
4a. Facility Name (If not institution, give street and number) 105 Highland Road		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
5. Social Security Number 213-18-6221	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	8. Date of Birth (Month, Day, Year) July 12 1920	9. Birthplace (State or Foreign Country) MD	
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 105 highland Road		10f. Zip Code 21060	
10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber		16b. Kind of Business/Industry Residential		17. Father's Name (First, Middle, Last) William Lee Jones	
18. Mother's Name (First, Middle, Maiden Surname) Anna Haigis		19a. Informant's Name/Relationship (Type, Print) Charles J. Jones, Sr. (son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8109 Parkway Drive, Baltimore, MD 21226	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem		20c. Location - City or Town, State Jan. 26 2004 Crownsville, Maryland	
21. Signature of Funeral Services Licensee 		22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. SQUAMOUS CELL CARCINOMA OF THE LUNGS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown					
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSIVE HEART DISEASE CORONARY ARTERY DISEASE					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D02583		29d. Date signed (Month, Day, Year) 01/23/2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anastacio Subong, M.D. 206 Crain Highway, Glen Burnie, MD 21061					
31. Date filed (Month, Day, Year) JAN 28 2004		32. Registrar's Signature 			

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01988

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Earl

D.

Johnson

2. Date of Death

January

19

04

3. Time of Death

3:05p. M

4a. Facility Name (If not institution, give street and number)

Overlea Manor Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

218-14-7245

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

12

05

22

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3927 Annellen Road

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th gradeCollege (1-4 or 5+)  
na16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Balto City Schools

17. Father's Name (First, Middle, Last)

Ernest Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Robinson

19a. Informant's Name/Relationship (Type, Print)

Margaret Johnson-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3927 Annellen Road, Baltimore Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King Memorial Park 1/27/04 Randallstown, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Carcinoma of Esophagus  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

8/11/2003

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Hypertension  
Anemia*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D 25391

29d. Date signed (Month, Day, Year)

1/26/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. KHAN, 5601-Loch Raven Blvd Baltimore 21239

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2004 01989

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernice Chase Johnson</b>			2. Date of Death Month <b>JANUARY</b> Day <b>25</b> Year <b>2004</b>		3. Time of Death <b>12:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>216-22-4763</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11 07 15</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1331 North Woodyear Street</b>			10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
	15. Decedent's Education (Specify only highest grade completed) <b>8th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic Worker</b>		16b. Kind of Business/Industry <b>Private</b>		
	17. Father's Name (First, Middle, Last) <b>Frank Chase</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie Castor</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Marlene Brown-Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1210 Whatcoat Street, Baltimore Md 21217</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park 1/30/04 Arbutus, Md</b>		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee <b>Hebe E. Hesse</b>		22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore Md 21215</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Pancreatic Cancer</b> Due to (or as a consequence of): <b>b. Liver Failure</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>						Approximate Interval Between Onset and Death <b>15 days</b> <b>15 days</b>
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Dr. Omar Hamze, M.D.</b>				29c. License number <b>AT 2438946-1545</b>		29d. Date signed (Month, Day, Year) <b>January 25, 2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>OMAR HAMZE. DEPT. OF MEDICINE - UNION MEMORIAL HOSPITAL</b>							
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Jean Jones  
04-00614  
MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01990

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jean Jones</b>		2. Date of Death Month Day Year <b>January 21, 2004</b>		3. Time of Death <b>2050 P M</b>
	4a. Facility Name (If not institution, give street and number) <b>University Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>
Funeral Director	5. Social Security Number <b>215-14-8291</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>11-28-22</b>	
	9. Birthplace (State or Foreign Country) <b>S.C.</b>		Usual Residence of Decedent		
10a. State <b>Md.</b>		10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>1613 N. Hilton Ave.</b>		10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) <b>8th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salad Chef</b>	
16b. Kind of Business/Industry <b>Resturant</b>		17. Father's Name (First, Middle, Last) <b>Willie Fedd</b>		18. Mother's Name (First, Middle, Maiden Sumame) <b>Novella Hill</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Karen Stokes Niece</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1348 Silverthorne Rd., Baltimore, Md. 21239</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cem.</b>		20c. Location - City or Town, State <b>1-28-04 Lansdowne, Md.</b>	
21. Signature of Funeral Service Licensee <b>D Ladys Wane</b>		22. Name and Address of Facility <b>Baltimore, Md. 21202 March F.H. East 1101 E. North Ave.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. hypertensive atherosclerotic cardiovascular disease with complications</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>aspiration pneumonia</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>1-21-04</b>		28b. Time of Injury <b>7:15 P M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>during catheter placement</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>University Hospital Baltimore, MD</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Patricia Aronica-Pollak MD</b>		29c. License number <b>O.C.M.E.</b>	
29d. Date signed (Month, Day, Year) <b>January 22, 2004</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PATRICIA ARONICA-POLAK 111 Penn Street, Baltimore, Maryland 21201</b>			
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature <b>Patricia Aronica-Pollak</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01991

1- For State Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Lillian Estelle Kloch</b>				2. Date of Death Month Day Year <b>January 24, 2004</b>		3. Time of Death <b>2:35 A<sup>M</sup></b>	
4a. Facility Name (If not institution, give street and number) <b>Genesis Eldercare</b>				4b. City, Town, or Location of Death <b>Severna Park</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>219-22-0270</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 22, 1916</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>512 Likeston Court</b>				10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>	
17. Father's Name (First, Middle, Last) <b>Mervin Catterton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Hershey</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mary F. Steinhice - daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>512 Likeston Court, Severna Park, Maryland 21146</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		Date <b>1/28/2004</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Ann Y. Zink</b>				22. Name and Address of Facility <b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229</b>			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Cerebrovascular accident</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death <b>days</b>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>[Signature] MD</b>				29c. License number <b>D 50725</b>		29d. Date signed (Month, Day, Year) <b>1-27-2004</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jennifer Riedinger 8601 Veterans Hwy M. Uersville, MD</b>							
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>				32. Registrar's Signature <b>[Signature]</b>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 01992

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Kernan

2. Date of Death

01 22 2004

3. Time of Death

2:37 p.m.

4a. Facility Name (If not institution, give street and number)

Ridgeway Manor Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

214-38-3232

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2/16/1939

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

241 Blakeney Rd.

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Technical Associate

16b. Kind of Business/Industry

Research

17. Father's Name (First, Middle, Last)

Herbert B. Kernan

18. Mother's Name (First, Middle, Maiden Surname)

Mary L. Bates

19a. Informant's Name/Relationship (Type, Print)

Jo Ann Kernan - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

241 Blakeney Rd. Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park

Date

1/26/04

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee

*Michael Schwartz*

22. Name and Address of Facility

Witzke Funeral Home of Catonsville 1630 Edmondson Ave. Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic lung carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1-2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Michael Schwartz*

29c. License number

D19667

29d. Date signed (Month, Day, Year)

01-22-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Schwartz 7310 Ritchie Highway Glen Burnie, Maryland 21061

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

*John H. Smith*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01993

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lois Marguerite Kaiserski

2. Date of Death

January 22, 2004

3. Time of Death

4:20 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Charlestown Retirement Community

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

214-14-7018

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 31, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

713 Maiden Choice Lane; Bldg. 2 (2307)

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Phillip Steinwedel

18. Mother's Name (First, Middle, Maiden Surname)

Anna Eilingsfeldt

19a. Informant's Name/Relationship (Type, Print)

Anne Weinkam - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

311 Orley Road; Catonsville, Maryland 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 1/26/04

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.  
1630 Edmondson Avenue; Catonsville, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01994

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET KEENE</b>				2. Date of Death Month <b>JANUARY</b> Day <b>25</b> Year <b>2004</b>				3. Time of Death <b>9:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Forest Haven Nursing Home</b>				4b. City, Town, or Location of Death <b>CATONSVILLE</b>				4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>212-36-2867</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 19, 1916</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>314 Osborne Avenue</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Secretary</b>				16b. Kind of Business/Industry <b>Bon Secour Hospital</b>					
17. Father's Name (First, Middle, Last) <b>John Travers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Delia A. Casserly</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Jennings M. Keene, Jr. (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>314 Osborne Avenue Catonsville, Maryland 21228</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakeview Memorial Park</b>		Date <b>1-30-04</b>		20c. Location - City or Town, State <b>Sykesville, Maryland</b>					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ALZHEIMERS DISEASE</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>						Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D28595-</b>		29d. Date signed (Month, Day, Year) <b>1/26/04</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JASNEEM LAKHTANI, 7220 PARK HEIGHTS AVE, BALD MD 21208</b>		31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2004 01995

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN FRANCIS KENNEDY, Jr.

2. Date of Death

Month Day Year  
JANUARY 24, 2004

3. Time of Death

1:30 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-14-7692

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 5, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2525 Pot Spring Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)  
5+ years16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Lawyer

16b. Kind of Business/Industry

State Government

17. Father's Name (First, Middle, Last)

John Francis Kennedy

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Leonard

19a. Informant's Name/Relationship (Type, Print)

Louis Wm. Steinwedel (Per. Rep.) 2906 Manhattan Ave. Baltimore, Maryland 21215

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

New Cathedral Cemetery

Date

1-28-04

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

George J. Ferrante

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Road Baltimore, Maryland 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
WEEKS

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

A. J. Helou, M.D.

29c. License number

D17695

29d. Date signed (Month, Day, Year)

January 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU, M.D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 6876  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01996

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Eugene Keaton</b>		2. Date of Death Month <b>January</b> Day <b>22</b> Year <b>2004</b>		3. Time of Death <b>1745 M</b>	
4a. Facility Name (If not institution, give street and number) <b>Union Mem. Hosp.</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
5. Social Security Number <b>245-07-6897</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>1-12-15</b>
9. Birthplace (State or Foreign Country) <b>N.C.</b>		10a. State <b>Md</b>			
10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1710 Carswell Stret</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b> College (1-4 or 5+) <b>College</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Roofer</b>		16b. Kind of Business/Industry <b>City of Baltimore</b>			
17. Father's Name (First, Middle, Last) <b>Crit Keaton</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Flack</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Joseph Keaton Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2803 Southern Ave, Baltimore, Md 21218</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cem.</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee <b>Y Ladys Wamer</b>		22. Name and Address of Facility <b>Baltimore, Md. 21202 March F.H. East 1101 E. North Ave.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Sepsis</b>		Approximate Interval Between Onset and Death <b>72 hours</b>			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pancreatitis</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>WZ Corbett MD</b>		29c. License number <b>AT2438946</b>	
29d. Date signed (Month, Day, Year) <b>January 22, 2004</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William L. Corbett MD, 201 East University Pkwy, Baltimore, MD 21218</b>			
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature <b>Benjamin B. Sparks</b>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01997

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Melvin Kirschbaum</u>				2. Date of Death Month <u>January</u> Day <u>21</u> Year <u>2004</u>		3. Time of Death <u>1:03 PM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Harbor Hospital Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>216 07 5173</u>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>83</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Aug. 12, 1920</u>	
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Maryland</u>		10b. County <u>Anne Arundel</u>		10c. City, Town or Location <u>Linthicum</u>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>514 Oak Grove Road</u>		10f. Zip Code <u>21090</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <u>WW II</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8th</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Machine Operator</u>		16b. Kind of Business/Industry <u>Brewery</u>			
	17. Father's Name (First, Middle, Last) <u>George Louis Kirschbaum</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Louisa W. Ahrens</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>Joan Kunaniec / Daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2543 Ironville Pike Columbia, Pennsylvania 17512</u>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Loudon Park Cemetery</u>		Date <u>1/27/2004</u>		20c. Location - City or Town, State <u>Baltimore, Maryland</u>	
	21. Signature of Funeral Service Licensee <u>Sharon R. Pett</u>		22. Name and Address of Facility <u>George J. Gonce Funeral Home, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225</u>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) a. <u>cardiac arrhythmia</u> Due to (or as a consequence of): b. <u>coronary artery disease</u> Due to (or as a consequence of): c. <u></u> Due to (or as a consequence of): d. <u></u> Approximate Interval Between Onset and Death <u>immediate</u> <u>years</u>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month <u></u> Day <u></u> Year <u></u>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <u></u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred <u></u>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u></u>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <u></u>				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>Tamara L. Kile, D.O.</u>				29c. License number <u>H0051791</u>		29d. Date signed (Month, Day, Year) <u>January 22, 2004</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Tamara L. Kile, D.O. 3001 South Hanover Street Baltimore MD 21225</u>								
31. Date filed (Month, Day, Year) <u>JAN 28 2004</u>		32. Registrar's Signature <u></u>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 01998

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Stanislaus A. Kowalewski

2. Date of Death

January 26 2004 10:05A M

3. Time of Death

Funeral Director

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213 96 9756

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

37

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 23, 1966

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

717 Marley Avenue

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electronics Technician

16b. Kind of Business/Industry

Electronics Manufacturing

17. Father's Name (First, Middle, Last)

Raymond E. Kowalewski

18. Mother's Name (First, Middle, Maiden Surname)

Frances K. Majka

19a. Informant's Name/Relationship (Type, Print)

Daleen Kowalewski / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

717 Marley Avenue Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Park

Date

1/30/2004

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

George J. Gonce Funeral Home, P.A.  
4001 Ritchie Highway Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non Hodgkin's Lymphoma stage 4

Due to (or as a consequence of):

b. Thrombocytopenia

Due to (or as a consequence of):

c. Anemia

Due to (or as a consequence of):

d. Dehydration

Approximate Interval Between Onset and Death

1 1/2 years

10 days

10 days

10 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown

3 ☐ Ectopic pregnancy

5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* O. Ghaleb M.D

29c. License number

RES 001

29d. Date signed (Month, Day, Year)

January 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OMID GHALAMBOR 3001 S Hanover St, Baltimore, MD 21225

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 01999

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RODERICK B. LOCKETT

2. Date of Death

Month Day Year  
JAN 25, 2004

3. Time of Death

9:41 am<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

GILCHRIST HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

214-56-5568

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUN. 25, 1952

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3222 YOSEMITE AVE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify: AFRICAN  
AFRICAN15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

AUTO MECHANIC

16b. Kind of Business/Industry

BALTIMORE CITY  
SCHOOL SYSTEM

17. Father's Name (First, Middle, Last)

JOHN LOCKETT

18. Mother's Name (First, Middle, Maiden Surname)

SHIRLEY BRICE

19a. Informant's Name/Relationship (Type, Print)

DENISE R. DAY (COUSIN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9819 BRIDLE BROOK DRIVE OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ST. THOMAS CEMETERY JAN. 30, 2004 RANDALLSTOWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WYLIE FUNERAL HOME PA

638 N. GIMLOR STREET BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Squamous cell cancer of tongue

Approximate  
Interval Between  
Onset and Death  
yearSequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown3 ☐ Ectopic pregnancy

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley GPMC 6701 N. Charles St. Balto. md 21204

31. Date filed (Month, Day, Year)

JAN 28 2004

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JESSIE J. LOTT

DAP

04-00561

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2004 02000

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JESSIE J. LOTT</b>			2. Date of Death Month Day Year <b>JANUARY 20, 2004</b>		3. Time of Death <b>10:35a M</b>	
	4a. Facility Name (If not institution, give street and number) <b>I-95 SOUTH JUST PRIOR I-695</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>255-50-6180</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 6, 1934</b>
	9. Birthplace (State or Foreign Country) <b>GEORGIA</b>						
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>3615 ELKADER ROAD</b>			10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TRUCK DRIVER</b>		16b. Kind of Business/Industry <b>TRANSPORTATION</b>		
	17. Father's Name (First, Middle, Last) <b>EDDIE LOTT</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>FRANCES BROWN</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>GEORGIA LEE LOTT / WIFE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3615 ELKADER ROAD BALTO, MD 21218</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>UNION BAPTIST CHURCH CEMETERY</b>		20c. Location - City or Town, State <b>1-27-04 MAYFIELD, GEORGIA</b>		
	21. Signature of Funeral Service Licensee <b>Tasha Z Greenberg</b>		22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL HOME 4905 YORK ROAD BALTIMORE, MD 21212</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple injuries</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>January 20, 2004</b>		28b. Time of Injury <b>10:35-A M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Interstate</b>		28d. Describe how injury occurred <b>pedestrian struck by vehicle</b>					
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>I-95 near 695 Baltimore County MD</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Tasha Z Greenberg MD</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JANUARY 21, 2004</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Tasha Z Greenberg MD, 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>JAN 28 2004</b>		32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner